Implicit models of mental disorder across the life-span : a comparison of older and younger adults

Thesis

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IMPLICIT MODELS OF MENTAL DISORDER ACROSS THE LIFE-SPAN: A COMPARISON OF OLDER AND YOUNGER ADULTS.

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I dedicate this piece of work to my family and especially to my grandmother, Tess Taylor.

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ABSTRACT

The implicit models of mental disorder held by a group of older adults (n=25) and younger adults (n=28) were examined, using a questionnaire focusing on vignette - case descriptions developed on the basis of previous research in the field. Older and younger adults were found to have highly comparable beliefs and opinions. There were some significant differences between the groups such as in the weight attached to certain causative factors in relation to specific problems and in terms of overall style of causal explanation, where older adults lay greater weight on the role of 'difficulties in personal relationships'. Older adults were also more likely to view inpatient psychiatric treatment as necessary for a number of problems and cited different sources for their views and opinions from younger adults. Clinical implications are discussed and suggestions for further research made.

INTRODUCTION

CONTEXT FOR THE CURRENT STUDY.

Older adults make up an increasing part of the general population and suffer from a high rate of mental health problems (Butler and Lewis, 1983). However, despite these two facts, mental health provision remains underdeveloped for older people (Carter and Mc.Goldrick, 1989; Oltmans, Neale and Davison, 1991). Older adults have relatively little power, status or economic control in western societies (Osgood, 1989) and may be the recipients of ageism amongst mental health professionals. As Genevay and Katz (1990) pointed out, ageism like sexism and racism may protect us from our own fears of helplessness, vulnerability and inferiority. Certainly surveys have shown that amongst clinical psychology trainees work with older adults has been seen to be unattractive (Woods and Britton, 1985). A study of 179 psychiatrists reported by Ford and Sbordone (1980) found that older patients were regarded as 'less ideal'.

Edinberg (1985) described certain myths about the elderly including that they suffered an irreversible loss of mental ability, loss of capacity for change and were emotionally fragile. Modern mental health services may not be unaffected by these myths. A standard primer for psychiatry (Gelder, Gath and Mayou, 1989) characterised the elderly as showing 'increasing cautiousness, rigidity and disengagement from the outside world' (p.597), whilst an introductory text for clinical psychology

(Garland in Marzillier and Hall, 1992) used the heading 'certainly a challenge' to describe working with this client group (p.175).

In particular, psychological, as opposed to biological, treatments seem to have been considered less emphatically and underemphasised in relation to older adults. As Lacey (1991) pointed out, despite a greater vulnerability to side effects, medication has consistently been prescribed as the treatment of choice and at higher levels in mental health treatment for this group. Psychological treatments can be dismissed altogether, witness Gelder et al.'s (1989) blanket statement 'interpretative psychotherapy is seldom appropriate for the elderly'(p.608). Despite Freud's famous antipathy towards psychological work with the elderly (Sadavoy and Leszcz, 1987), psychological treatments based on a range of models including the psychodynamic have been shown to be clinically utile (Wattis and Martin, 1994).

Part of what lies behind the lack of development and use of talking therapies for older adults appears to be the belief that older adults are less psychologically minded and more somatically oriented in their own understanding of mental health problems. This perspective is readily encountered in the literature (e.g. Bradbury, 1991; Hughston, Christopherson and Bonjean, 1989). However, as Tantam (1995) pointed out, 'psychological mindedness' is a poorly operationalised concept which often confuses personality characteristics with holding a certain set of values and which furthermore may not actually affect the efficacy of psychological therapies as much as one might expect (e.g. McCallum and Piper, 1990).

It is clear however that a reasonable argument can be constructed to support the view that older adults may hold a different perspective on mental health from younger adults. Differing models of mental health have been shown to exist across different ethnically based cultures (e.g. Fernando, 1991) and there may be mileage in considering older adults as having to some extent their own culture. As Knight (1986) pointed out, older adults grew up in eras when cultural values were clearly different from the contemporary and have lived through major societal changes. Kleinman and Good (1985) have stated that people who are suffering will be influenced by their cultural setting in how they make sense of their problems and as Knight (1986) pointed out, older adults grew up before the era when psychology became 'popularised' and mental health services socially acceptable. Knight described older adults as growing up with 'a pre-psychological worldview' (p.37).

As Brewin (1988) pointed out, attribution theory has indicated that 'human beings have an in-built desire to explain their world' (p.89) and Furnham (1990) has stated that 'common sense' is often merely an amalgam of cultural maxims, shared beliefs, proverbs and fables. Exploration of the implicit beliefs that non-expert people hold about what they encounter in their lives has been relatively extensively addressed in relation to a number of phenomena such as physical health (e.g. Turk, Rudy and Salovey, 1986; Calnan and Johnson, 1985; Williams, 1983 and Helman, 1978), crime (Campbell and Muncer, 1990), poverty (Feather, 1974) and personality (Furnham, 1990).

Whilst some such as Gergen and Semin (1990) have argued that these implicit or folk beliefs are inferior to scientific understanding and operationalised rather feebly, Furnham (1988a, 1988b) argued that not all lay theorising is so inconsistent and that neither is scientific theorising always so robust, specific or falsifiable. Research into the implicit sense or understanding that ordinary people, be they young or old, make of mental disorder has however been historically rather limited. This research will be addressed in the following sections.

RESEARCH CONDUCTED IN THE 1950'S, 60'S, 70'S AND 80'S.

Historically, investigations concerning the attitudes and attributions that people hold and make in relation to mental disorder have often been directed towards gauging public acceptance of 'mental patients' or towards the degree of recognition of 'mental illness' and the labelling of it as such. Much of this research was carried out in America and reflected the prevailing desire of professionals in that era to transport the dominant medical model ideology into the views and minds of the public. A key aim was to encourage the notion that mental illness was 'an illness like any other' (Rabkin, 1974). Questions concerning the sense ordinary people made of the nature or cause of mental ill-health themselves were less directly addressed.

As Rabkin (1974) reported, research into public attitudes towards mental health problems came into its own in the 1950's. Probably the earliest investigation into this area was published just before the beginning of this decade by Ramsey and Seipp (1948a,1948b) and did attempt to address the issues of both

aetiology and treatment. The 345 participants were asked only six questions to this end and hence, as Rabkin (1974) pointed out, the concepts of aetiology presented were limited. However the results did indicate that participants ranked emotional and environmental factors higher than they did physical or hereditary factors. Steneck (1951), surveying 240 residents of St.Louis, reported finding both organic and environmental factors foremost in the lay understanding of what brought about mental health problems.

One researcher from this era whose work has remained influential, particularly in terms of methodology despite the fact that it was never formally published, is Shirley Star. Star (1955) devised case vignettes representing various mental health problems and presented them to 3,500 people during the 1950's. She found that they resisted applying the label 'mental illness' unless the case description presented extremely disturbed behaviour. Cumming and Cumming (1957) researched the effects of a six month educational campaign in a rural town in Canada during 1951 and, similarly, found that residents considered a wide range of behaviours within the range of normality. However, once certain boundaries were transgressed, the label mentally ill was applied and people were likely to become socially isolated.

A more widely known research project carried out in the 1950's is the six year survey reported by Nunnally (1961). Four hundred respondents selected to be nationally representative were investigated using a seven point agreement scale in relation to a 180 item opinion list. Ten somewhat weak factors related to

aetiology were derived through factor analysis. These included the role of will power, organic causes and environmental conditions.

Schwartz (1957) interviewed the wives of 20 men diagnosed as psychotic and hospitalised. She found that these women went through an active process of reconstruing their husbands' difficulties. Early attempts were made at normalising or reframing the behaviour within the realms of the understandable and although many came to adopt the label mental illness after contact with psychiatric professionals, this was still often conceptualised from a social rather than an intrapsychic standpoint.

Hollingshead and Redlich (1958), investigating attitudes towards psychiatric treatment amongst the general public found that higher social status was associated with greater awareness of psychiatric services. Lower social class was associated with the belief that mental illness was a somatic disease.

Studies in America in the 1960's also tended to reflect the medical-psychiatric model of that era and often addressed the questions of whether lay people used the label 'mental illness' in the same way as psychiatrists, as well as issues of treatment and social desirability. Crocetti and Lemkau (1963) presented three of the Star vignettes to residents of Baltimore and found that half of them identified the case histories as showing mental illness requiring medical attention. Only four percent did not identify any of the vignettes in this way. Crocetti and Lemkau

compared their work with the findings of Star (1955) and reported that identification of mental illness had risen from 34 percent to 78 percent in relation to the 'simple schizophrenia' case description, from 75 to 91 percent for 'paranoid disorder' and from 29 to 62 percent for 'alcoholism'. Ring and Schein (1970) interviewed 400 adults in Philadelphia and found a widespread adoption of the medical model. Thus, it can be seen that studies in the 60's did seem to reflect a growing adherence to the medical model of mental illness at least in so far as that meant identifying mental 'illness' and and agreeing to the desirability of medical care (Crocetti, Spiro, Lemkau and Siassi, 1972; Rabkin, 1974).

One other study from that era which could be seen as having implications for how ordinary people viewed the 'nature' of mental health problems was conducted by Phillips (1966). Phillips presented four of Star's vignettes with one of his own representing a normal man, to female participants. Although 98 percent of respondents indicated that they would consider the 'normal' man as an acceptable son-in-law, this figure dropped to 17 percent when the case description carried the additional information that he was an ex-mental patient. Hence it can be seen that however mental illness was conceived, it was not seen as a transient condition but as something more enduring.

As Sarbin and Mancuso (1972) stated, the apparent lay allegiance to the medical conceptual framework for mental illness was perhaps not fully borne out, at least in relation to the

social acceptability of people with mental health problems. Researchers from that era also consistently found non-medical factors such as unpredictability and aggression as pivotal to lay diagnosis (Rabkin, 1974).

Other findings suggested that older and lower status respondents tended to view the mentally ill more critically and that the availabilty of local psychiatric services also tended to foster the conceptualisation of problems within a psychiatric framework (Rabkin, 1974). Interestingly a study conducted by Weinstein and Brill (1971) found that amongst a sample of 517 psychiatric patients the tendency was to stress environmental, interpersonal and emotional factors as lying behind their difficulties and that hereditary and biological factors were frequently ruled out by them.

Bates (1975) conducted a large scale community survey of 1000 people in Sydney, Australia, which presented them with varying explanatory models for mental illness. Participants tended to endorse the 'medical benevolent model' and generally did not endorse the idea that mental illness was a socially induced phenomenon. This finding is perhaps understandable in the light of the work of Calhoun, Selby and Wroten (1977). Whilst investigating the relationship between social rejection and causal understanding of mental illness, they found that problems understood in social and or external frames of reference were not generally included in the ambit of mental illness per se, the defining features of which were, for their sample, internal - albeit psychological or physical.

A national survey in Ireland in 1973, conducted on behalf of the Mental Health Association of Ireland, looked at a representative sample of 1578 people and found that from a list of twelve factors, money worries, loneliness and tension in the home were most heavily weighted as being prejudicial to mental health. As Barry (1991) pointed out, however, the list presented was largely composed of social factors and 60 percent of the sample endorsed the view that mental illness could be inherited. In another study in Ireland, Moran (1977) reported that a medical model for mental illness tended to predominate in rural communities and amongst the older and less well educated respondents.

Norman and Malla (1983), using case vignettes, looked more specifically at high school students. They found that whilst physical and psychosocial aetiologies were both supported, a psychosocial orientation was related to a more optimistic view with regard to prognosis. Keatinge (1985) looked at differences between different communities in their views on schizophrenia and its treatment. Older respondents were found not only to favour a more custodial approach but also held more negative views on the psychiatric facilites where this could be offered. Interestingly, a study carried out in Israel by Rahav, Struening and Andrews (1984) also found older adults to be more authoritarian in their views on mental illness but, in addition to this, found that they were more likely to endorse interpersonal difficulties as the key factor in aetiology. This suggests that negative or authoritarian attitudes do not necessarily equate with a model of pathological processes operating within the person.

Hasin and Link (1988) investigated the lower rates of depression reported amongst people who were born prior to the second world war. They hypothesised that this might relate to a decreased rate of recognition of depression as a psychological entity amongst the elderly. One hundred and fifty-two community residents were shown a case vignette depicting major depression at a relatively mild level of severity. They found that older respondents were much less likely to characterise the vignette as a psychological or emotional problem than younger adults. (A later unpublished and admittedly smaller study which investigated older and younger clients with depression reported by Ogden, 1990, failed to support this finding.)

The work carried out in the four decades following the war has been criticised by Rabkin (1974), Brockman, D'Arcy and Edmonds (1979) and by Barry (1991). Barry (1991) described it as restricted both in focus and in the methods used whilst also arguing that views other than the psychiatric definition were in danger of being ignored and remaining unexplored.

RESEARCH DURING THE CURRENT DECADE.

The present author was able to find three published accounts which investigated lay models of mental disorder during the current decade: Barry and Greene (1992); Hall, Brockington, Levings and Murphy (1993); and Wolf, Pathare, Craig and Leff (1996a,b).

The first of these studies was, in the view of the current author, seminal and merits some attention. Barry and Greene

(1992) attempted to address the cognitive components of implicit lay beliefs about mental disorder more specifically and as they related to issues of recognition, interpretation, causation, seriousness, treatment and recovery. They interviewed 53 people from a rural community in Ireland, their sample containing roughly equal numbers of men and women ranging in age from 17 to 67 years. Their methodology utilised seven case description vignettes including four of the original Star vignettes and three new case studies. The problems presented were paranoia, anxiety, alcoholism, schizophrenia (negative symptomatology), depression, phobia and schizophrenia (positive symptomatology). The gender of vignette actors, and the order in which the vignettes themselves were presented, were systematically varied. Each vignette was followed by a series of open response format questions relating to the factors mentioned earlier. Participants were interviewed in their homes, their responses recorded on tape and later analysed by means of a systematic method of content analysis where different responses were coded according to their generic content. Responses were coded as a total set in relation to each vignette and inter-coder reliability was established at a high level.

Barry and Greene (1992) reported a high recognition rate for the existence of a problem with most vignettes being rated as such by between 94 and 100 percent of participants. The anxiety vignette was an exception with 30 percent of people not considering it to represent a problem. Responses in relation to the interpretation of the problem were subsequently coded as falling into three different categories; characterological, pathological and situational. Barry and Greene found that the

alcoholism, phobia, depression, paranoia and schizophrenia-positive vignettes were mostly described within a pathological framework (using labels such as 'mental illness', 'mental problems', or more specific psychiatric or lay style diagnoses), whereas the anxiety and schizophrenia-negative vignettes were mostly described within a characterological framework (i.e. relating to personality). Situational interpretations, whilst generated less frequently, were associated primarily with the depression and schizophrenia-negative vignettes. Taken as a whole, 55 percent of the responses generated in relation to the vignettes were pathological, whereas 33 percent were characterological and 7 percent situational. Perhaps an interesting reflection of the cultural context in which this work was conducted was the 43 percent of responses to the schizophrenia-positive vignette (5 percent of the whole) which placed the problem described within a religious framework.

In the Barry and Greene (1992) study, seven major aetiological categories were derived when responses to do with causation were coded. Interestingly, participants tended to restrict themselves to one or two causal categories. Taken as an overall response set, personality factors accounted for 24 percent of the explanatory statements, childhood factors for 22 percent, social factors for 15 percent, stressful life events for 14 percent , somatic factors for 13 percent, relationship problems for 8 percent and religious beliefs for 2 percent. A further two percent were coded in a residual miscellaneous category. What is interesting about this data set is the low priority that was given to explanatory factors that fit with the medical model. The other factors (not including the religious and the

miscellaneous), which could roughly be subsumed under a psychosocial rubric, accounted for some 83 percent of the responses weighed against the 13 percent which were somatic in orientation. What was also clear was that rather than holding an overall generic model of mental disorder, participants tailored their explanations specifically to the different vignettes. The anxiety vignette was predominantly explained in terms of personality factors with many references to thinking style. The alcoholism vignette was predominantly explained in terms of somatic and personality factors. The phobia vignette was typically attributed to a traumatic chidhood experience whilst the depression vignette led to the highest number of attributions related to social problems, often drawing on gender issues such as unemployment for men or domestic isolation for women. Paranoia and schizophrenia-negative were mostly attributed to personality and childhood problems whist schizophrenia-positive was linked to stressful life events.

Barry and Greene's (1992) participants typically considered the problems presented to be serious. The anxiety vignette was rated as the least serious with 58 percent considering it thus. The number of participants who indicated that the vignette actors needed help was also high (ranging from 81 to 100 percent). In all seven cases the majority of respondents were optimistic about the likely outcomes although many participants described the steps which they considered necessary to reach such ends.

Barry and Greene (1992) reported no systematic differences on the basis of class, gender or age. Older participants, however, did tend to pathologise the schizophrenia vignettes more readily

and were less optimistic about the likely outcomes. Barry and Greene concluded that 'lay perceptions and beliefs may not be as confused and unsophisticated as previous studies have implied'(p.156). They also pointed out that the causal models implicit in the responses generated by their participants did, to some extent, mirror the different causal models held by competing sections of the professional mental health community.

It would seem that Barry and Greene's (1992) sample did not support the medical model of mental disorder in quite the way that had been proclaimed of some participants in the chiefly American research of previous decades. Barry and Greene's research remains significant because of its range, comprehensiveness and subsequent demonstration that reported implicit models will vary in response to the presentation of different disorders. Another finding worthy of note was that the high use (55 percent) of pathological interpretations, including the like of 'mental illness' and others, was not synonymous with a medical model of causation as was demonstrated by the low usage of medical model type causal explanations (13 percent as opposed to 87 percent). The open ended question structure allowed a deeper and more sophisticated taxonomy of implicit lay beliefs than could envisaged using a closed response format.

A larger survey was conducted by Hall, Brockington, Levings and Murphy (1993). They commisioned Market Opinion and Research International (MORI) to interview a thousand people in two different areas which had differing psychiatric services (one community based and one centred around a traditional psychiatric hospital). Participants were sampled so as to be representative

of the communities as a whole. The investigators looked at demographic factors, attitudes towards the mentally ill, knowledge of local psychiatric facilities, identification of certain behaviour as 'mental illness', the perceived causes of that behaviour, and which agencies were thought likely to be helpful. To answer the latter three questions, Hall et al. utilised two considerably amended Star vignettes and two other vignettes which they devised themselves.

The vignettes in Hall et al.'s (1993) study were organised in pairs, two showing schizophrenia (paranoid schizophrenia and schizophrenic defect state) and two showing neurosis (obsessional neurosis and depression). One vignette from each of these pairs was used with each participant and the pairs were also taken as units for purposes of statistical analysis. Responses were chosen freely from a pre-set list of alternatives. In relation to causation for the behaviours described in the vignette the response set consisted of eighteen phrases which could be seen as descriptive and or explanatory; hence terms such as 'mental illness', 'anxiety' and 'depression' were presented alongside 'brain damage', 'genetic', 'childhood experiences' and 'financial worries'.

Thus, it can be seen that Hall et al.(1993) may have been making certain assumptions about terms such as 'mental illness' and their meaning for respondents which in the light of Barry and Greene's (1992) work may not be tenable, (similarly their pairing of vignettes may not have been mixing like with like). This lack of clarity may have lay behind what Hall et al. regarded as poor recognition rates of 'mental illness' in the vignettes. Hall et

al. made no reference to how the list of alternatives was devised or arrived at, which must raise questions as to bias and validity. Furthermore the freedom to indicate any number of factors might have lead to a bias of over inclusion.

Nonetheless the results are of some interest. Insecurity and childhood experiences were often mentioned as causes as were unspecified stress and specified stressors such as bereavement, financial difficulties, homelessness and unemployment. Elderly participants more frequently chose the option 'no cause' (28 percent compared with 18 percent in the other age groups) and young people more often selected 'unemployment' as a cause than older people. Other findings included the fact that psychiatrists were less often mentioned as a source of help by those who had been mentally ill themselves than by all other groups, and in a separate part of the study, that advanced age was consistently associated with intolerant attitudes.

Wolf, Pathare, Craig and Leff (1996a,1996b) presented the findings from a census of attitudes to mental illness in two inner city areas prior to the opening there of supported housing for the mentally ill. Two hundred and fifteen people were interviewed using the electoral register for sampling purposes and a sample balanced for gender with an age range of 18 - 79 years was achieved. The authors were keen to recognise that their population was not representative of the general population as it included a disproportionate number of people of higher social class, few elderly and a rich ethnic mix, the latter factor not

surprisingly being found to effect a large degree of variance upon the results. Initial findings suggesting that negative attitudes seemed to be linked to a lack of knowledge were investigated further.

Wolf et al.(1996b) measured knowledge through the administration of a series of questions where participants were asked inter alia, to name types of mental illness, differentiate mental illness from mental handicap, state what they thought were the main causes of mental illness, whether it could be passed down through families and what sort of treatment might be appropriate. When participants were asked to identify the causes of mental illness, 83 percent cited environmental factors. These included stressors such as relationship, family, work and financial problems. Other causes cited included heredity (39 percent), organic causes (22 percent), accidents (11 percent) and substance abuse (21 percent). Seventy-three percent believed that mental illness could be passed down in families. These findings would seem to indicate that many respondents saw a causal role for both endogenous and environmental factors. However, it should be remembered that previous research has clearly shown that people reserve the label mental illness for a more restricted range and more disturbed set of behaviours than mental health professionals and it is likely that Wolf et al.'s (1996b) findings are not readily generalisable to a wide range of problems. Driving responses was the term and concept of 'mental illness'. Quite what this concept meant to Wolfe et al.'s participants is unclear. Furthermore as Barry and Greene (1992)

revealed, lay people tend to be selective and eclectic in their causal attributions when presented with case descriptions showing differing types of psychological problem. Wolfe et al. concluded that certain demographic subgroups had less knowledge of mental illness than others and that, especially amongst older adults, negative attitudes were fuelled by that lack of knowledge.

RATIONALE FOR THE CURRENT STUDY.

As has been seen, certain assumptions are often made about the way that older adults construe their worlds and in particular how they construe mental health problems. Research into the implicit models of mental disorder held by ordinary people in general has varied in scope, methodology and findings. Whilst some studies have emphasised social and environmental factors, others have emphasised a medical type model, whilst others still have reported both. In relation to older adults the picture is also mixed, for instance Moran (1984) indicated that older adults are more medically minded whilst Rahav et al.(1984) found older people keener to emphasise interpersonal factors. More recently Barry and Greene (1992) found no systematic effects for age.

These studies were conducted across different countries and eras so their diversity may not be so surprising. As Barry and Greene (1992) pointed out, implicit models are not unamenable to change in differing contexts. However, none of the studies described focused specifically and systematically on potential differences in the implicit models of mental disorder held by

older and younger adults, or did so in a contemporary British setting. Furthermore, although various studies have indicated some mixture of differing factors, there has been little attempt to weight these factors importance in relation to each other and the genesis of mental disorder, other than counting the number of statements generated which fall into different explanatory frameworks. It is possible that studies demonstrating a greater number of social and environmental statements may reflect a greater ease at generating statements relating to everyday life and a smaller degree of aptitude in elaborating upon more 'specialist' bio-medical notions.

On this basis it was decided to conduct a study comparing the the implicit models of mental disorder held by older and younger adults which would reflect the current setting and time and would also allow for the weighting of different factors in relation to each other.

AIMS.

The aim of this study was to see how older and younger adults differed in their implicit models of mental disorder as measured by their responses to a number of vignette - case descriptions portraying a range of mental health problems.

HYPOTHESES.

The following ten hypotheses were generated. It was thought that older and younger adults would differ on:

(i) the extent to which they recognise case descriptions as representing a problem,

(ii) the interpretative labels that they would choose in order to describe the nature of the problems presented as case descriptions,

(iii) the causative factors they chose to explain what caused a given problem,

(iv) the overall differential choice of causative factors selected when the case descriptions are taken as a whole,

(v) the extent to which they would consider the problems to be serious,

(vi) the extent to which they would consider the people in the case descriptions as requiring help or treatment,

(vii) the extent to which they would see 'family and friends' and 'professionals' as the source of the above help,

(viii) the extent to which they would consider removal from the community and inpatient treatment as necessary for recovery,

(ix) their views on the prospect of recovery either without or with professional help, and,

(x) the sources which they reported their ideas and views as coming from.

METHOD

PARTICIPANTS.

OVER-VIEW.

Participants were to be recruited from community settings where they either worked or congregated for other purposes. Thus the samples were to be non-clinical and, as far as possible, representative of the general public. It was recognised that this would include some individuals who would have personal experience or knowledge of mental ill-health. Age parameters were set at 18 to 30 years, inclusive, for younger adults and 60 years and above for older adults.

Recruitment sources.

Older adults sample.

Four sources were approached to recruit participants for the older adults sample. These were:

(i) A drop-in centre for older people based in South London and run by an organisation called 'Elders First'. This organisation has a brief similar to better known organisations such 'Age Concern' and receive funding from the local authority. They offer community, social and advice facilities on an informal basis. Contact was made on the telephone and a visit arranged to explain the nature and details of the research .

(ii) A social club for senior citizens organised by the Salvation Army and held in a Salvation Army community centre in South London. This facility was open to all local people above the age of 60 and did not require active participation in church or religious activities. Contact was arranged by letter (see Appendix 1).

(iii) An organisation called 'The University of The 3rd Age'. This organisation recruits members on the basis of older adults (post retirement) who wish to remain intellectually active. They invite regular speakers on various topics and organise study groups. The branch approached by the researcher was based in a large town within commuting distance of London. Contact was made on the telephone with their secretary. A list of individuals who might be interested in participating was provided by the secretary and these individuals were canvassed by letter (see Appendix 2) including a copy of the information sheet (as described later) prior to a large meeting.

(iv) Informal contacts. One individual, who lived locally and was known informally to contacts of the author, was approached and given an information sheet (as described later) and expressed a desire to take part in the research.

All three organisations above were keen to take part in the research and did so readily. It was felt that accessing older participants from clearly different settings would enhance the generalisability of the findings. None of the participants were known to the author. Participation across the groups was divided such that roughly half came from the University of the 3rd Age and half came from the two social facilities.

Younger adults sample.

Two approaches were initiated to recruit a sample of younger adults. These were:

(i) Formal approach to companies.

Initially five organisations were approached via their personnel departments. These organisations were of varying size and considered likely to employ people in the requisite age bracket but were not involved in health or social care provision. They crossed the public / private sector divide in recognition that differing business cultures might be reflected in differing attitudes to participation in health service research. The organisations were: two London borough councils, a large broadcasting company, a medium sized London professional football club and a company offering large scale computing services to other businesses. These organisations were approached by an initial letter explaining the nature of the research and its possible contribution to health service provision (see Appendix 3). This letter was followed up after a period of one month by a second letter offering further details (see Appendix 4). A number of follow-up phonecalls were made, principally after the second letter but also between the two letters sent out. Where possible a named individual was identified as dealing with the request. At a later stage a specific department of a London borough was approached by means of a more specific letter aimed at their participation which also offered to initiate some service such as a 'stress management seminar for staff members'

in return for participation, subject to negotiation (see Appendix 5). This was offered after discussions with the researcher's supervisor and as an incentive to participation.

Of the above organisations, one responded to the initial letter to decline to participate. The others either declined to participate (citing lack of time etc.) when contacted by 'phone, or did not respond. The broadcasting company personnel department later passed the request on to the head of their occupational health department whom the author attempted to contact by 'phone. An appointment was later offered by the occupational health officer but was received at a point when it was thought unlikely that time would allow for further developments. The specific department of a local London borough who were offered the opportunity of some service in return for their participation did not respond to the letter sent to them.

It remains unclear why the organisations canvassed seemed reluctant to engage in discussions about the research or even to actively decline to participate. When reasons were cited these related to a lack of time and or appropriate personnel. It may be that the organisations were reluctant to actually say 'no' to health service research but were ambivalent about the nature of the research itself (i.e. relating to mental health issues). One organisation appeared to be paralysed by a lack of company policy on the issue.

(ii) Informal networking.

As a result of the difficulties, described above, in recruiting companies to participate, a second approach was initiated.

Individuals known either first or second hand to the author who worked in non health or social service provision settings were provided with information sheets (as described later). They were asked to distribute these amongst colleagues whom they knew to be within the requisite age group or alternatively amongst people whom they knew from other settings. When a suitable number of potential participants were identified a visit was arranged by the researcher.

This method of recruitment proved more productive than the former approach and generated the source of participants accessed for inclusion in the younger adults sample. However, this approach was not entirely free from practical difficulties and three arranged visits were cancelled at short notice when potential participants stated that they had either changed their minds or were for practical reasons unable to take part. This approach did, however, have the benefit of accessing individuals from a greater range of sources which can provide a greater degree of confidence in the generalisability of the findings. None of the participants in this sample were known to the author.

DESCRIPTION OF ACTUAL PARTICIPANTS.

There were 53 participants in total. Twenty-five were older adults and twenty-eight were younger adults. The older adults included seven males and eighteen females, the age range was 61 to 86 years (mean = 71.9, sd = 8.660). The younger adults included twelve males and sixteen females, the age range was 22 to 30 years (mean = 25.3, sd = 1.982). The sample did not contain any people from ethnic minorities. Further demographic

information on marital status, occupational status, educational attainment and reported personal experience of mental disorder can be seen in the 'preliminary analyses' section of the results.

APPARATUS AND MATERIALS.

OVERVIEW.

A questionnaire was developed for use in this study which was based on previous research carried out by Barry (Barry,1991; Barry and Greene,1992). Barry presented seven hypothetical case descriptions (or 'vignettes') of people with mental health problems to participants in her research, each followed by a series of eight questions relating to recognition, interpretation, causal explanation, seriousness, treatment and recovery.

Four of Barry's (1991) vignettes were taken and adapted from the previous work carried out by Star (1955) whilst a further three were devised by Barry herself. Five of these vignettes were selected for the current research (three of which were devised by Star and two of which were devised by Barry). The vignettes were minimally adapted to make them more culturally consonent with the current setting, for instance a reference to Catholic Mass was omitted and a phrase referring to a vignette actor as 'another kind of person' was ommitted as a 'leading' form of words. An additional vignette describing senile dementia was devised by the researcher. The presentation of the gender of vignette actors in the current questionnaire was systematically varied.(The vignettes, male and female versions, may be seen in

Appendix 6.) This step was taken so as to err on the side of caution against possible biases. Barry and Greene (1992), however, reported no systematic differences in their findings on the basis of the gender of the vignette actors.

Seven of Barry's (1991) original questions were also adopted for the current questionnaire. Barry used a closed and open-ended response format in separate studies. In the current research the questions relating to interpretation and causation of the difficulties were followed by forced choice answers reflecting the categories or types of response offered by participants in Barry's open-ended study which she subsequently coded and for which she demonstrated a satisfactory level of inter-coder reliability. Participants were limited to choosing three (in rank order of importance) and excluding others if they wished, in light of Barry's report that her participants typically generated responses in a small number of categories (usually no more than two). Categories which were neither ranked as important nor excluded were given a low weighting. In relation to the questions concerning recognition, seriousness, treatment and recovery, the forced choice responses offered by Barry in her closed ended study were adopted. These responses were adapted, however, so as to remove potential responses such as 'don't know' and 'not sure'. This was to encourage respondents who might lack confidence in asserting elements of their implicit thinking. The questions were further adapted and added to, to separate out the concepts of professional and non-professional help (i.e. help from family and friends), address the issue of whether the conditions presented represented problems for those around the

individual described, and to investigate whether participants considered removal from circulation (i.e. inpatient treatment) as necessary for treatment/recovery.

A final section in the questionnaire sought demographic information from each respondent accessing their gender, age marital status, current or previous occupation, education level and personal experience of the problems described. A further question sought to establish what sources the respondents felt they had drawn upon in developing their ideas as accessed in the questionnaire.

PILOTING OF MEASURE.

The questionnaire was piloted on a sample of ten people (6 women and 4 men) known to the author to establish ease of reading and the length of time required to fill it in. The age range of these individuals was 28 - 72 years (mean = 42.5 yrs, sd = 15.76 yrs, median = 35.5 yrs). They came from a range of professions (two were retired). None worked in health care provision, although one had a psychology degree. Only one was university educated although six had been to some form of college (e.g. art school, Royal Naval College etc.).

Following from this exercise some minimal alterations were made to the text of the questionnaire. Individuals standardly reported no problems in understanding the questions. The length of time required to fill it in varied between 15 and 45 minutes with most participants taking around 30 minutes.

VALIDITY OF MEASURE.

The validity of the vignettes with regard to diagnostic content was addressed in the following manner:
The author in conjunction with a chartered clinical psychologist scrutinised the vignettes to see whether they portrayed symptoms in line with those described in DSM IV (American Psychiatric Association, 1994). All the vignettes were considered to demonstrate symptoms described as co-occuring in DSM IV. Furthermore, four of the six vignettes were considered to demonstrate sufficient criteria for psychiatric diagnoses. In reaching these judgements it was recognised that, with the exception of one vignette, duration of difficulties had not been specified. However it was taken as assumed that they were of some duration rather than recent in onset. The problems described in the vignettes are listed below:

(i) Paranoia (Star, 1955). This individual exhibited paranoid symptoms and might be diagnosable as having 'Schizophrenia of the Paranoid Type'. However the vignette did not include enough characteristic signs or the necessary mixture of both positive and negative symptoms to justify this diagnosis.

(ii) Anxiety (Star, 1955). This individual demonstrated two of a minimum of three symptoms which would be required for a diagnosis of 'Generalised Anxiety Disorder'. They did also present a number of other dysfunctional symptoms. However, as a constellation of symptoms this presentation would be unlikely to justify a formal psychiatric diagnosis.

(iii) Alcoholism (Star, 1955). This individual presented with a range of difficulties which could attract a diagnosis of 'Substance Dependence'.

(iv) Phobia (Barry, 1991). This individual presented with a range of symptoms for which the most germane diagnosis was considered to be 'Specific Phobia - Situational Type'.

(v) Depression (Barry, 1991). The symptoms described were considered to be sufficient for a diagnosis of 'Major Depressive Episode'.

(vi) Dementia (devised by the current researcher). This person presented with symptoms which could attract a diagnosis of 'Dementia'. The dementia might be either of the 'Alzheimer's' or 'Vascular Type'. It is assumed that other information, which is not presented in the vignette and which might lead to some other differential diagnosis, is not pertinent.

It needs to be pointed out that meeting the criteria for a formal psychiatric diagnosis was not considered to be a pre-requisite for vignettes to be included in the current study. Many presentations at mental health services or at general practices do not warrant formal psychiatric diagnoses and in many cases people present with a mixture of differing symptoms. Considered relevant to this was the issue of 'clinical validity', that is the extent to which practitioners in the field would recognise these vignettes as describing people similar to those who might present at mental health services.

To examine this form of validity the following procedure was followed:

A brief questionnaire (see Appendix 7) was sent out to thirteen psychiatrists (ten of whom had been personally identified and three of whom whose names were unknown where the questionnaire was to be passed on by a known clinical psychologist) and twelve identified clinical psychologists who worked in the field of older adults. The questionnaire presented the vignettes and asked whether the professionals considered them to be "reasonable descriptions of the type of problems which are likely to be encountered by mental health clinicians". Further to this the professionals were invited to state whether they thought that any of the descriptions would warrant a psychiatric diagnosis and if so which would be most appropriate.

Nine Clinical psychologists (75%) and eight psychiatrists (61.5%) responded to the questionnaire as follows:

(i) Paranoia (Star, 1955). All of the respondents considered this to be a reasonable description of somebody who might present clinically. Four clinical psychologists suggested possible diagnoses which were as follows; paranoia; paranoid personality; paranoid illness; and paranoid psychosis (assuming his beliefs are irrational). A further clinical psychologist who suggested further assessment stated that it might be paranoid psychosis, schizophrenia or frontal type dementia. Six psychiatrists suggested possible diagnoses of; paranoid state; paranoid psychosis /paranoid schizophrenia; paranoid personality - maybe psychosis; paranoid psychosis; paranoid schizophrenia /depressive

illness; delusional disorder or paranoid schizophrenia. One psychiatrist stated that more information was required.

(ii) Anxiety (Star, 1955). All of the clinical psychologists and five of the psychiatrists considered this to be a reasonable description of the sort of person who might present clinically. One psychiatrist ommitted to fill in this part of the questionnaire and two indicated that they did not consider the vignette to be a 'reasonable description'. Four clinical psychologists suggested potential diagnoses which were as follows; depression, anxiety - secondary to personality disorder; brain damage, bereavement; agitated depression; GAD, depression. Two psychiatrists proffered diagnoses which were; depressive personality disorder; depression, personality disorder. The two psychiatrists who did not accept the vignette as a reasonable description of somebody who might present clinically made comments as follows; 'might be dysthymia.....sounds like me and I'm not ill!' and 'unlikely to be referred to a psychiatrist'.

(iii) Alcoholism (Star, 1955). All nine clinical psychologists and six of the psychiatrists considered this to be a reasonable description of someone who might present clinically. Five of the clinical psychologists made comments / suggested potential diagnoses as follows; addicted to alcohol, more information required; alcoholism; alcohol dependency /abuse; 'no evidence of mental health problems'; probably alcoholic. Three psychiatrists proffered diagnoses as follows; alcohol dependency; alcohol dependence syndrome; alcohol abuse /dependence. The two psychiatrists who did not consider this vignette to be a resonable description made comments as follows; 'older adults

don't have jobs' and 'description of a drunk, could apply to lots of people'.

(iv) Phobia (Barry, 1991). All of the clinical psychologists and psychiatrists rated this vignette as a reasonable description of somebody who might present clinically. Five clinical psychologists suggested potential diagnoses which were as follows; claustrophobia (two cases); phobic anxiety(two cases); agoraphobia /panic disorder. Seven psychiatrists suggested diagnoses as follows; phobic anxiety /panic attacks; phobic anxiety; phobic anxiety disorder; specific phobia; claustrophobia; agoraphobia; phobic anxiety or simple phobia (claustrophobia). One psychiatrist stated that they needed more information.

(v) Depression (Barry, 1991). All of the clinical psychologists and psychiatrists considered this to be a reasonable description of somebody who might present clinically. Six of the clinical psychologists suggested that the individual either had depression or was depressed. The psychiatrists suggested diagnoses as follows; severe depression; depression (two cases); depressive episode; possible dysthymia, maybe depression; depressive illness (two cases); depression, adjustment disorder.

(vi) Dementia (current author). All of the clinical psychologists and psychiatrists considered this to be a reasonable description of somebody who might be seen clinically. Five clinical psychologists suggested potential diagnoses / commented as follows; early /mild dementia, requires further assessment; depression /dementia /organic state ?; either dementia, pseudo-

dementia or subacute confusional state; insufficient information... ? dementia; probably a dementing process. Six of the psychiatrists suggested diagnoses as follows; early degenerative dementia; possibly developing dementia; possible senile dementia of the Alzheimer's type; early dementing illness; organic mental state; cognitive impairment - dementia ?.

Thus it can be seen that four of the vignettes were considered by all the professionals canvassed to be reasonable descriptions of the type of people who are referred to mental health services, although there was some variation in the potential diagnoses proferred. The two vignettes which did not receive unanimous backing (Anxiety and Alcoholism) did nonetheless receive support at a rate of 87.5 percent and 89 percent each. The anxiety vignette was a little unusual in that it was identified in most cases as a disorder other than the one which it was supposed to represent.

RELIABILITY.

An attempt was made to investigate test-retest reliability. As the piloting procedure had left the questionnaire essentially unchanged it was felt acceptable to use this same sample for the purpose of investigating reliability. The questionnaire was readministered after a period of two weeks.

A system for scoring similarity of responses was devised and can be seen in Appendix 8. The system devised could be considered as relatively generous as it allowed some responses which were considered to be very close to be coded as matching, however, it

appeared to offer most face validity. The reliability ratings can also be seen in Appendix 8. As can be seen there, the range of reliability scores for each individual item ranged from 30 percent to 100 percent, although only four items were below 50 percent. These were: on the 'anxiety' vignette, question twelve, 30 percent; on the 'alcoholism' vignette, question three - causal factors, 'personality' and 'social situation', 30 and 40 percent; on the 'phobia' vignette, question eleven, 30 percent. Overall, the reliability for this questionnaire was 81 percent and each vignette scored close to or above 80 percent.

ESTABLISHMENT OF FINAL QUESTIONNAIRE.

Following on from the piloting procedure and the validation and reliability studies the final form of the questionnaire was established. The questionnaire was shortened by the removal of the vignette representing 'Anxiety'. This was to shorten the length of time that the questionnaire would take to complete as it was felt that a maximum of around thirty minutes was desirable. The 'Anxiety' vignette was removed in light of the inconsistent labels attached to it by professionals during the clinical validation exercise. (The reliability rating with this vignette removed was 81.5%.)

The questionnaire has not been reproduced in full here as essentially it contains five reproductions of the same set of questions. However the introductory sheets can be seen in Appendix 9, the vignettes in Appendix 6, the repeated questions in Appendix 10, and the final (chiefly demographic questions) section in Appendix 11.

PROCEDURE.

Participants were recruited on an informal basis from the various settings previously described. Thus participants were variously seen in work, community or domestic settings. An information sheet (see Appendix 12) was in all cases provided at least 24 hours in advance which explained the nature of the research and emphasised the voluntary nature of participation. The information sheet took a vignette from Barry (1991) which had not been used in the current project and presented it as an example of the kind of descriptions which were in the questionnaire. Attached to the information sheet was a consent form which individuals signed. As part of standard procedure the researcher was always present when the questionnaires were being filled in. This helped to assure confidentiality in that the questionnaires were taken away by the researcher in person and meant that the researcher was on hand to answer any queries or concerns as they arose. In practice some individuals wished to say something of their own experience of mental health problems or more commonly wished to know more about the nature of the research. No participants appeared unduly concerned by the nature of the material in the questionnaire. Participants retained the information sheets which provided a contact number for the researcher. Following completion of the questionnaire participants were asked whether they would like to recieve a short report on the overall findings of the research at a later date and provided with a separate sheet on which they could place their name and address for this purpose (see Appendix 13). In almost all cases this offer was taken up.

ETHICAL APPROVAL.

Prior to implementation a proposal outlining the nature of the research (and giving an example of the questionnaire) was submitted to the Ethics Committee based at, but independent of the regional clinical psychology training scheme. Ethical approval was granted. Correspondence from and to the committee can be seen in Appendix 14.

STATISTICAL ANALYSIS.

This study was comparitative and measured the differing frequencies with which the two independent samples chose differing responses. The data obtained in this study were mainly at the nominal level and in some instances at the ordinal level. Therefore non-parametric analyses were applied. These were conducted using SPSSWIN (Norusis, 1993). All hypotheses were two-tailed and analysis was primarily by means of chi square. In other instances analysis was by means of Mann Whitney tests, where this was the case it is clearly indicated in the results section. Fisher's exact test was applied to the chi square where appropriate and Mann Whitney tests were corrected for ties.

In view of the relatively high number of analyses conducted a probability level of .01 was set in advance to justify confidence in the findings. However, in light of the exploratory nature of the research, results in a band of confidence between .05 and .01 were considered worthy of report. Please note: where certain data

points were missing the percentages expressed in the results section are the valid percentages, that is the percentages derived from the available responses.

RESULTS

PRELIMINARY ANALYSES.

Preliminary analyses were conducted on the demographic information collected from each participant. This was to ascertain that differences between groups were attributable to age and not to other demographic factors.

Table 1 shows that whilst the older adults sample contained proportionately more females (72 as opposed to 57.1 percent), this difference was not statistically significant. However, Table 2 shows that the groups were significantly different ($p < .0001$) on marital status. Most older adults were married or widowed whilst a smaller number were separated/divorced or single. The younger adults were for the most part single whilst those who were not were co-habiting.

Table 1: Comparison of groups by gender.

	Older Adults		Younger Adults	
	no.	%	no.	%
Male	7	28	12	42.9
Female	18	72	16	57.1

chi = 1.2677 df = 1 p = .2602

Table 2: Comparison of groups by marital status.

	Older Adults		Younger Adults	
	no.	%	no.	%
Single	2	8.3	20	71.4
Married	10	41.7		
Co-habiting			8	28.6
Widowed	8	33.3		
Separated/ Divorced	4	16.7		
Not known	1			

chi = 44.6840 df = 4 p < .0001

As Table 3 shows, 45.8 percent of the older adults sample attended secondary education whilst 41.7 percent went on to tertiary education. The younger adults figure for tertiary education was significantly higher at 89.3 percent ($p < .0024$). Social class was evaluated on the basis of occupation (or occupation prior to retirement in the case of older adults). The responses participants gave when asked to state occupation were coded in line with the National Census guidelines (HMSO, 1991) and are shown in Table 4. As can be seen the two groups were not significantly different in terms of their social class as based on occupation. This analysis did not include the categories 'student' or 'unemployed' as the wording on the questionnaire was likely to preclude responses coded in this fashion for older adults.

Table 3: Comparison of groups by level of education.

	Older Adults		Younger Adults	
	no.	%	no.	%
Primary-only	1	4.2	1	3.6
Secondary	11	45.8	2	7.1
Tertiary	10	41.7	25	89.3

chi = 14.4370 df = 3 p < .0024

Table 4: Comparison of groups by social class as based on occupation.

	Older Adults		Younger Adults	
	no.	%	no.	%
Prof.	8	34.8	5	18.5
Man.+Tech.	4	17.4	5	18.5
Skill occ. non-man.	5	21.7	4	14.8
Skill occ. man.	1	4.3	3	11.1
Part skill. occ.	2	8.7	5	18.5
Unskilled	3	13.0	1	3.7
Student			3	11.1
Unemployed			1	3.7
Not known	2		1	

chi = 4.200 df = 5 p = .5210

(NB: this analysis was conducted using the first six categories listed, only.)

Table 5: Comparison of groups by personal experience of mental disorder (judged by participants in response to presented material).

		Old.Ads.		Young.Ads.		chi	df	p
		no.	%	no.	%			
Yes		22	88	24	85.7	.0602	1	1.0000
No		3	12	4	14.3			
Self	(yes)	4	16	9	32.1	1.8592	1	.1727
	(no)	21	84	19	67.9			
Close fam.	(yes)	7	28	13	46.4	1.9090	1	.1671
	(no)	18	72	15	53.6			
Other rel.	(yes)	6	24	3	10.7	1.6537	1	.2785
	(no)	19	76	25	89.3			
Frnd or wrk.-mate	(yes)	11	44	16	57.1	.9129	1	.3400
	(no)	14	56	12	42.9			
Other	(yes)	6	24	3	10.7	1.6537	1	.2785
	(no)	19	76	25	89.3			

As Table 5 shows, there were no significant differences between the groups in terms of their personal experience of mental disorder as measured by their responses to the question, 'have you ever come across any of the problems described today ?'. Four of the older adults (16 percent) stated that they had experienced some of the problems described themselves. Nine of the younger adults (32.1 percent) stated that they had experienced some of the problems described. The most common sources from which both older and younger adults cited encountering the problems described were 'close family' and 'friends or workmates'. When

older and younger adults cited the nature of the contacts marked as 'other', these were either through paid or voluntary work such as 'the samaritans'. One younger adult participant noted that she had encountered 'schizophrenia' in a friend of a friend's sister.

HYPOTHESIS ONE.

This hypothesis addressed whether older and younger adults would differentially recognise the case descriptions as representing a problem. Table 6 shows that recognition rates in response to being asked 'do you think this person has a problem?' were high for both groups, ranging from 78.61 percent to 100 percent.

Older adults unanimously rated three of the vignettes as showing a person with a problem ('paranoia', 'alcoholism' and 'depression') whilst younger adults did so on one vignette ('depression'). Ninety-six percent of older adults rated the 'phobia' vignette as representing a problem, whilst 96.4, 89.3 and 85.7 percent of younger adults rated the 'paranoia', 'alcoholism' and 'phobia' vignettes as representing a problem respectively. The lowest recognition rates for the two groups were on the 'dementia' vignette. Eighty-eight percent of older adults and 78.6 percent of younger adults rated this vignette as showing a person who had a problem.

Only two vignettes elicited a 'no' response to the question 'do you think this person has a problem ?'. One younger adult responded in this way to the 'paranoia' vignette whilst two older

Table 6: Recognition of a problem: rates for vignettes compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Yes	25	100	.9100	1	1.0000
		No					
		D/k					
	Yng.Ads.	Yes	27	96.4			
		No	1	3.6			
		D/k					
Vig.2.(Alcoholism)	*Old.Ads.*	Yes	25	100	2.8393	1	.2380
		No					
		D/k					
	Yng.Ads.	Yes	25	89.3			
		No					
		D/k	3	10.7			
Vig.3.(Phobia)	*Old.Ads.*	Yes	24	96	1.6354	1	.3546
		No					
		D/k	1	4			
	Yng.Ads.	Yes	24	85.7			
		No					
		D/k	4	14.3			
Vig.4.(Depression)	*Old.Ads.*	Yes	25	100			
		No					
		D/k					
	Yng.Ads.	Yes	25	100			
		No					
		D/k					
Vig.5.(Dementia)	*Old.Ads.*	Yes	22	88	2.8393	2	.2418
		No	2	8			
		D/k	1	4			
	Yng.Ads.	Yes	22	78.6			
		No	1	3.6			
		D/k	5	17.9			

adults and one younger adult responded in this way to the 'dementia' vignette. Three vignettes elicited 'don't know' responses. Three younger adults responded in this way to the 'alcoholism' vignette. One older adult and four younger adults responded in this way to the 'phobia' vignette whilst one older adult and five younger adults responded in this way to the 'dementia' vignette. There were no statistically significant differences between the groups and therefore no support for Hypothesis (i).

HYPOTHESIS TWO.

This hypothesis addressed the issue of differences in preferred interpretative labels/constructs across groups, in response to the question 'if this person has a problem, what is the nature of their problem ?'. Possible responses were 'something to do with their personality', 'some kind of mental illness or something similar' and 'a reaction to their situation or to something which has happened to them'. The results are presented in Table 7.

Most older adults described the person in the 'alcoholism' vignette as having a personality problem, the people in the 'paranoia' and 'dementia' vignettes as being mentally ill or something similar and the people in the 'phobia' and 'depression' vignettes as experiencing reactions to their situations. Most younger adults described the people in the 'paranoia' and 'dementia' vignettes as being mentally ill or something similar

Table 7: Interpretative labels assigned to vignettes compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Pers.	5	20	.4009	2	.8184
		Men.Il.	15	60			
		Reac.	5	20			
	Yng.Ads.	Pers.	4	14.3			
		Men.Il.	17	60.7			
		Reac.	7	25			
Vig.2.(Alcohol.)	*Old.Ads.*	Pers.	15	60	2.7055	2	.2585
		Men.Il.	3	12			
		Reac.	7	28			
	Yng.Ads.	Pers.	12	42.9			
		Men.Il.	2	7.1			
		Reac.	14	50			
Vig.3.(Phobia)	*Old.Ads.*	Pers.	5	20	1.3029	2	.5213
		Men.Il.	8	32			
		Reac.	12	48			
	Yng.Ads.	Pers.	9	32.1			
		Men.Il.	6	21.4			
		Reac.	13	46.4			
Vig.4.(Depress.)	*Old.Ads.*	Pers.	4	16	.0955	2	.9534
		Men.Il.	9	36			
		Reac.	12	48			
	Yng.Ads.	Pers.	5	17.9			
		Men.Il.	9	32.1			
		Reac.	14	50			
Vig.5.(Dement.)	*Old.Ads.*	Pers.	3	12.5	1.3839	2	.5006
		Men.Il.	20	83.3			
		Reac.	1	4.2			
	Yng.Ads.	Pers.	1	3.7			
		Men.Il.	25	92.6			
		Reac.	1	3.7			

and the people in the 'alcoholism', 'phobia' and 'depression' vignettes as experiencing reactions to their situations. Their were no statistically significant differences between the groups, therefore Hypothesis (ii) was not supported.

Participants were also asked a supplementary question, 'in your own words, what do you think is the problem ?'. The responses to this varied but generally consisted of a mixture of psychiatric-type diagnostic labels, lay descriptors of state (e.g. 'unbalanced', 'mental problem') and statements addressing the possible origin of the difficulties. A summary of these can be seen in Appendix 15.

HYPOTHESIS THREE.

This hypothesis addressed the weight which participants gave a predetermined range of causative factors. These were 'something biological or physical', 'what went on in this person's childhood', 'difficulties in personal relationships', 'something to do with their personality or the way they think about things', 'something to do with their social situation or circumstances', and 'stress or pressure from what's happening in their life'. Participants ranked up to three factors as predominant and left the remaining factors either unmarked or excluded by an 'x'. This created a weighting range of 0 - 4 (where o = 'x', 1 = unmarked, 2 = third rank, 3 = second rank, 4 = first rank). Each factor could potentially receive a maximum weighting of 100 with the older sample and 112 with the younger sample if every participant ranked it as most important. Tables 8-12 show the median and mode

weightings and percentage of the total possible weighting (t.p.w.) that each causative factor received, as well as the results of comparative analysis by means of Mann Whitney tests.

Table 8: Vignette 1.(Paranoia). Weight attached to potential causative factors compared by group.

		% tpw	median	mode	z	p
Bio.-phys.						
	Old.Ads.	39	1	1	-1.2548	.2096
	Yng.Ads.	50.9	2	4		
Childhood						
	Old.Ads.	62	3	1	- .8962	.3702
	Yng.Ads.	53.6	2	1		
Diff.pers.rel.						
	Old.Ads.	44	1	1	-1.1099	.2670
	Yng.Ads.	34.8	1	1		
Pers.or think						
	Old.Ads.	48	1	1	-2.2156	.0267*
	Yng.Ads.	66.1	3	3		
Soc.sit.or circ.						
	Old.Ads.	38	1	1	- .2461	.8056
	Yng.Ads.	35.7	1	1		
Stress + pres.						
	Old.Ads.	47	2	1	- .1685	.8662
	Yng.Ads.	47.3	2	1		

nb: * denotes trend at the p < .05 level.

Table 8 shows the weightings for the 'paranoia' vignette. As can be seen, the most heavily weighted causative factor for older adults was childhood experience, whilst for younger adults it was

personality and cognitive style. The least important factor for older adults was social situation/circumstances, whilst for younger adults it was difficulties in personal relationships. The difference in importance accorded by the two groups to personality and cognitive style showed a trend approaching significance ($z = -2.2156$, $p < .0267$).

Table 9: Vignette 2.(Alcoholism). Weight attached to potential causative factors compared by group.

		% tpw	median	mode	z	p
Bio.-phys.						
	Old.Ads.	38	1	1	-1.4815	.1385
	Yng.Ads.	26.8	1	1		
Childhood						
	Old.Ads.	38	1	1	-1.5828	.1135
	Yng.Ads.	27.7	1	1		
Diff.pers.rel.						
	Old.Ads.	50	1	1	-1.4269	.1536
	Yng.Ads.	35.7	1	1		
Pers.or think						
	Old.Ads.	55	2	1	-1.6091	.1076
	Yng.Ads.	67.9	3	4		
Soc.sit.or circ.						
	Old.Ads.	38	1	1	-3.2087	.0013***
	Yng.Ads.	63.4	3	3		
Stress + pres.						
	Old.Ads.	62	3	3	- .1113	.9114
	Yng.Ads.	62.5	3	3		

nb: *** denotes significance at the P < .001 level.

Table 9 shows the weightings for the 'alcoholism' vignette. As can be seen the most heavily weighted causative factor for older adults was stress and pressure, whilst for younger adults it was personality and cognitive style. Least important for older adults were biology/physiology, childhood experience and social situation/circumstances, whilst for younger adults it was biology/physiology. The difference in importance accorded by the two groups to social situation/circumstances was statistically significant at the $p < .001$ level ($z = -3.2087$, $p < .0013$).

Table 10: Vignette 3.(Phobia). Weight attached to potential causative factors compared by group.

		% tpw	median	mode	z	p
Bio.-phys.						
	Old.Ads.	41	1	1	- .3415	.7327
	Yng.Ads.	41.1	1	1		
Childhood						
	Old.Ads.	54	1	1	- .1146	.9087
	Yng.Ads.	53.6	1.5	1		
Diff.pers.rel.						
	Old.Ads.	27	1	1	- .7767	.4373
	Yng.Ads.	23.2	1	1		
Pers.or think						
	Old.Ads.	56	2	1	-1.4206	.1554
	Yng.Ads.	68.8	3	4		
Soc.sit.or circ.						
	Old.Ads.	32	1	1	- .6890	.4908
	Yng.Ads.	28.6	1	1		
Stress + pres.						
	Old.Ads.	53	2	1	- .1678	.8668
	Yng.Ads.	54.5	2	1		

Table 10 shows the weightings for the 'phobia' vignette. As can be seen, the most heavily weighted causative factor for both the older adults and the younger adults was personality and cognitive style. The least important factor was, for both groups, difficulties in personal relationships.

Table 11: Vignette 4.(Depression). Weight attached to potential causative factors compared by group.

	% tpw	median	mode	z	p
Bio.-phys.					
Old.Ads.	29	1	1	- .0660	.9474
Yng.Ads.	31.3	1	1		
Childhood					
Old.Ads.	26	1	1	-1.1752	.2399
Yng.Ads.	29.5	1	1		
Diff.pers.rel.					
Old.Ads.	62	3	1	-2.3833	.0172*
Yng.Ads.	41.1	1	1		
Pers.or think					
Old.Ads.	51	2	1	- .4631	.6433
Yng.Ads.	55.4	2	1		
Soc.sit.or circ.					
Old.Ads.	54	2	1	-1.0847	.2780
Yng.Ads.	62.5	2	2		
Stress + pres.					
Old.Ads.	53	2	1	-1.9411	.0522*
Yng.Ads.	69.6	3	3		

nb: * denotes trend at the p < .05 level.

Table 11 shows the weightings for the 'depression' vignette. As can be seen the most heavily weighted factor for older adults was difficulties in personal relationships, whilst for younger adults it was stress and pressure. The least important factor for both older and younger adults was childhood experience. The differences in importance accorded by the two groups to difficulties in personal relationships and to stress/pressure

Table 12: Vignette 5.(Dementia). Weight attached to potential causative factors compared by group.

		% tpw	median	mode	z	p
Bio.-phys.						
	Old.Ads.	70	4	4	-3.0213	.0025**
	Yng.Ads.	94.6	4	4		
Childhood						
	Old.Ads.	19	1	1	-1.4334	.1518
	Yng.Ads.	14.3	1	1		
Diff.pers.rel.						
	Old.Ads.	20	1	1	-1.0971	.2726
	Yng.Ads.	16.1	1	1		
Pers.or think						
	Old.Ads.	35	1	1	-1.6720	.0945
	Yng.Ads.	22.3	1	1		
Soc.sit.or circ.						
	Old.Ads.	33	1	1	- .1667	.8676
	Yng.Ads.	34.8	1	1		
Stress + pres.						
	Old.Ads.	62	3	3	-2.8654	.0042**
	Yng.Ads.	36.6	1	1		

nb: ** denotes significance at the p < .01 level

demonstrated a trend approaching significance (diff.pers.rel., $z = -2.3833$, $p < .0172$, stress + pres., $z = -1.9411$, $p < .0522$).

Table 12 shows the weightings for the 'dementia' vignette. As can be seen the most heavily weighted factor for both groups was biological/physiological. Least important, again for both groups, was childhood experience. The differences in importance given to the factors biological/physiological and stress/pressure were statistically significant at the $p < .01$ level (bio.phys., $z = -3.0213$, $p < .0025$, stress.pres., $z = -2.8654$, $p < .0042$).

Therefore Hypothesis (iii) was given limited support, with significant differences for the 'alcoholism' and 'dementia' vignettes and differences approaching significance for the 'paranoia' and 'depression' vignettes.

HYPOTHESIS FOUR.

This hypothesis addressed whether older and younger adults would differentially use the causative factors to explain mental health problems in general, by looking at how they were weighted when the five vignettes were taken as a whole. This created a scale of importance which ran from zero to 500 for older adults and from zero to 560 for younger adults with the higher scores representing the highest weightings possible should every single participant rate any given causative factor as the most important for all vignettes. Each individual's ratings on any given factor can be seen as representing a point on a scale running from zero to 20 for older adults and running from zero to 28 for younger

adults when the ratings across vignettes are collapsed. Table 13 shows the mean weighting given by individuals from the two groups for each vignette as well as the percentage of the total possible weighting for the groups as a whole and results of analysis of difference by means of Mann Whitney tests. For this longer scale, means and standard deviations are presented as these were considered more informative (although it is acknowledged that the data are not parametric).

As can be seen from Table 13, the most heavily weighted causative factor for older adults was stress and pressure (55.4 percent t.p.w.) whilst for younger adults it was personality and cognitive style (56.1 percent t.p.w.). The least important factor for older adults was social situation/circumstances (39 percent t.p.w.) whilst for younger adults it was difficulties in personal relationships (30.2 percent t.p.w.). Taken in rank order of importance the older adults weighted the causative factors as follows, starting with the most important: stress and pressure, personality or cognitive style, biology/physiology, difficulties in personal relationships, childhood experience, and social situation/circumstances. Younger adults weightings for the causative factors, ranked in order of importance, were as follows: personality and cognitive style, stress and pressure, biology/physiology, social situation/circumstances, childhood experience, and difficulties in personal relationships. With the exception of one causative factor there were no significant differences between the groups. This factor was difficulties in personal relationships, (older adults, 40.6 percent t.p.w.,

Table 13: Weight attached to potential causative factors for all vignettes taken as a whole compared by group.

		% tpw	mean	sd	z	p
Bio.-phys.						
	Old.Ads.	46	9.200	3.379	-1.2016	.2295
	Yng.Ads.	51.4	10.286	3.452		
Childhood						
	Old.Ads.	39.8	7.960	2.791	- .8702	.3842
	Yng.Ads.	35.7	7.143	2.534		
Diff.pers.rel.						
	Old.Ads.	40.6	8.120	2.877	-2.5991	.0093**
	Yng.Ads.	30.2	6.036	2.168		
Pers.or think						
	Old.Ads.	49	9.800	2.784	-1.4725	.1409
	Yng.Ads.	56.1	11.214	3.521		
Soc.sit.or circ.						
	Old.Ads.	39	7.800	2.739	-1.3288	.1839
	Yng.Ads.	45	9.000	2.815		
Stress + pres.						
	Old.Ads.	55.4	11.080	3.785	- .6627	.5075
	Yng.Ads.	54.1	10.821	2.803		

nb: ** denotes significance at the $p < .01$ level.

younger adults, 30.2 percent t.p.w.). The higher importance accorded to this factor by older adults was significant at the $p < .01$ level ($z = -2.5991$, $p < .0093$). Therefore, Hypothesis (iv) received support in relation to this factor.

HYPOTHESIS FIVE.

This hypothesis addressed whether older and younger adults considered the problems described to be serious. There were two questions which related to this and which followed each vignette. The first simply asked 'do you think the problem is serious ?'. Responses were on a four point scale which ran from 'not at all serious', through 'not so serious' and 'serious' to 'very serious'. The second question asked 'how much difficulty might this person cause those around them ?'. This was followed by a four point scale which ran from 'no difficulty at all', through 'not much difficulty' and 'some difficulty' to 'a lot of difficulty'. For the purpose of analysis these questions were combined to form an eight point scale of seriousness for each vignette. Again, means and standard deviations are presented, although it is acknowledged that the data are not parametric.

Table 14: Ratings of seriousness for each vignette compared by group.

		mean	sd	z	p
Vig.1.(Paranoia)	*Old.Ads.*	5.120	1.092	- .1472	.8829
	Yng.Ads.	5.107	.994		
Vig.2.(Alcohol.)	*Old.Ads.*	4.320	.900	-1.5059	.1321
	Yng.Ads.	4.000	.903		
Vig.3.(Phobia)	*Old.Ads.*	3.000	1.118	- .8055	.4205
	Yng.Ads.	2.679	.983		
Vig.4.(Depress.)	*Old.Ads.*	3.960	1.274	- .6586	.5102
	Yng.Ads.	3.750	.967		
Vig.5.(Dementia)	*Old.Ads.*	3.920	1.382	-1.2810	.2002
	Yng.Ads.	3.481	1.528		

As can be seen from Table 14, both groups rated the 'paranoia' vignette as most serious, whilst both groups also rated the 'phobia' vignette as least serious. Analysis by means of Mann Whitney tests revealed no significant differences between the groups on any vignette. There was, therefore, no support for Hypothesis (v).

HYPOTHESIS SIX.

This hypothesis addressed participants' responses to the question 'does this person need help ?'. As can be seen from Table 15, there was a high rate of responses affirming the need for help. Both the 'paranoia' and the 'depression' vignettes received one hundred percent ratings for needing help, from older and younger adults. The lowest ratings were for the 'dementia' vignette; 91.7 percent of older adults and 85.7 percent of younger adults responded that the person described needed help. There were no statistically significant differences between the groups for any vignette and therefore Hypothesis (vi) was not supported.

HYPOTHESIS SEVEN.

This hypothesis addressed the sources of help or treatment which participants considered to be germane or necessary. As can be seen from Table 16, a majority of participants in both groups considered family and friends to be an appropriate source of help in relation to the 'depression' and 'dementia' vignettes. In addition to this, half the older adults also considered family and friends to be an appropriate source of help in relation to

Table 15: Perceived need for help/treatment compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Yes	25	100			
		No					
	Yng.Ads.	Yes	28	100			
		No					
Vig.2.(Alcohol.)	*Old.Ads.*	Yes	25	100	1.8557	1	.4920
		No					
	Yng.Ads.	Yes	26	92.9			
		No	2	7.1			
Vig.3.(Phobia)	*Old.Ads.*	Yes	23	95.8	.7803	1	.6146
		No	1	4.2			
	Yng.Ads.	Yes	25	89.3			
		No	3	10.7			
Vig.4.(Depress.)	*Old.Ads.*	Yes	25	100			
		No					
	Yng.Ads.	Yes	28	100			
		No					
Vig.5.(Dementia)	*Old.Ads.*	Yes	22	91.7	.4486	1	.5030
		No	2	8.3			
	Yng.Ads.	Yes	24	85.7			
		No	4	14.3			

the 'alcoholism' vignette and just over half the younger adults considered them to be an appropriate source of help in relation to the 'phobia' vignette. A minority of participants in both

groups considered family and friends to be the appropriate source of help in relation to the 'paranoia' vignette. Similarly, a little less than half the older adults considered family and friends to be an appropriate source of help in relation to the 'phobia' vignette and a little less than half of the younger adults also, in relation to the 'alcoholism' vignette. There were no statistically significant differences between the groups.

Table 16: Family and friends as source of necessary help compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Yes	8	36.4	.0447	1	.8327
		No	14	63.6			
	Yng.Ads.	Yes	11	39.3			
		No	17	60.7			
Vig.2.(Alcohol.)	*Old.Ads.*	Yes	12	50	.0660	1	.7927
		No	12	50			
	Yng.Ads.	Yes	13	46.3			
		No	15	53.6			
Vig.3.(Phobia)	*Old.Ads.*	Yes	11	45.8	.1842	1	.6678
		No	13	54.2			
	Yng.Ads.	Yes	14	51.9			
		No	13	48.1			
Vig.4.(Depress.)	*Old.Ads.*	Yes	12	54.5	3.2682	1	.0706
		No	10	45.5			
	Yng.Ads.	Yes	22	78.6			
		No	6	21.4			
Vig.5.(Dementia)	*Old.Ads.*	Yes	16	69.6	1.7659	1	.1839
		No	7	30.4			
	Yng.Ads.	Yes	23	85.2			
		No	4	14.8			

As Table 17 shows, a majority of participants in both groups considered professional help to be necessary in relation to all vignettes. Affirmative response rates for older adults ranged from 100 percent for the 'paranoia' vignette to 78.3 percent for the 'phobia' vignette. For younger adults affirmative response rates ranged from 96.4 percent for the 'paranoia' vignette to 60

Table 17: Professionals as source of necessary help compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Yes	24	100	.8740	1	1.0000
		No					
	Yng.Ads.	Yes	27	96.4			
		No	1	3.6			
Vig.2.(Alcohol.)	*Old.Ads.*	Yes	22	88	.3535	1	.7078
		No	3	12			
	Yng.Ads.	Yes	23	82.1			
		No	5	17.9			
Vig.3.(Phobia)	*Old.Ads.*	Yes	18	78.3	.0017	1	.9672
		No	5	21.7			
	Yng.Ads.	Yes	21	77.8			
		No	6	22.2			
Vig.4.(Depress.)	*Old.Ads.*	Yes	21	87.5	.2849	1	.7101
		No	3	12.5			
	Yng.Ads.	Yes	23	82.1			
		No	5	17.9			
Vig.5.(Dementia)	*Old.Ads.*	Yes	18	90	5.1136	1	.0237*
		No	2	10			
	Yng.Ads.	Yes	15	60			
		No	10	40			

nb: * denotes trend at the p < .05 level.

percent for the 'dementia' vignette. There was one difference between the groups which fell within the range of a trend approaching significance. Ninety percent of older adults considered professional help to be necessary in the case of the 'dementia' vignette, whilst for younger adults, 60 percent thought so.

Participants were also asked a supplementary question in relation to Hypothesis (vii). They were asked who, if they considered professional help to be necessary, would the person in each vignette 'need to see' ?. The responses to these (which included psychiatrists, doctors, counsellors, psychologists, social services and voluntary organisations) can be seen in Appendix 16. Hypothesis (vii) was not supported, with the exception of the trend approaching significance for the 'dementia' vignette with professional help.

HYPOTHESIS EIGHT.

This hypothesis addressed participants' responses to the question, 'in your opinion would this person need to go and stay in a psychiatric hospital to get better ?'. As can be seen from Table 18, the majority of participants thought that inpatient psychiatric treatment would not be necessary, in response to the 'alcoholism', 'phobia', 'depression' and 'dementia' vignettes. In response to the 'paranoia' vignette, a majority of the older adults (70.8 percent) indicated that inpatient treatment would be necessary, whilst a majority of the younger adults (67.9 percent) did not agree.

Table 18: Requiring in-patient psychiatric treatment compared by group.

			no.	%	chi	df	p
Vig.1.(Paranoia)	*Old.Ads.*	Yes	17	70.8	7.7381	1	.0054**
		No	7	29.2			
	Yng.Ads.	Yes	9	32.1			
		No	19	67.9			
Vig.2.(Alcohol.)	*Old.Ads.*	Yes	6	25	2.9130	1	.0066**
		No	18	78			
	Yng.Ads.	Yes					
		No	28	100			
Vig.3.(Phobia)	*Old.Ads.*	Yes	1	4.2	.0124	1	1.0000
		No	23	95.8			
	Yng.Ads.	Yes	1	3.6			
		No	27	96.4			
Vig.4.(Depress.)	*Old.Ads.*	Yes	5	20.8	3.7726	1	.0836
		No	19	79.2			
	Yng.Ads.	Yes	1	3.6			
		No	27	96.4			
Vig.5.(Dementia)	*Old.Ads.*	Yes	7	29.2	9.4376	1	.0026**
		No	17	70.8			
	Yng.Ads.	Yes					
		No	28	100			

nb: ** denotes significance at the $p < .01$ level.

There were three statistically significant differences between the groups at the $p < .01$ level. In response to the 'paranoia', 'alcoholism' and 'dementia' vignettes, significantly more older

than younger adults indicated that inpatient treatment was necessary (par., $p < .0054$; alc., $p < .0066$; dem., $p < .0026$). (It should be noted that a small number of participants wrote on their questionnaires that they found this question difficult to answer in relation to the 'dementia' vignette as they felt the issues of hospitalisation and recovery to be separate in that case.) Hypothesis (viii) was therefore supported in relation to these vignettes.

HYPOTHESIS NINE.

This hypothesis addressed participants' views on the prospect of recovery for the people described in the vignettes, in the first instance without professional help and in the second instance with professional help. In both cases four options were available for selection. These were, that the individual would 'recover completely', would 'recover but the problem will recur', would 'recover but always show signs of having had (the) problem' or that they would 'never recover'.

In relation to the 'paranoia' vignette, as can be seen from Table 19, a majority of older adults indicated the partial recovery stage 'will recover but always show signs of having had (the) problem' (36 percent) when there was no professional help. When there was professional help a larger majority (60 percent) favoured the partial recovery stage 'will recover but the problem will recur'. A majority of younger adults (46.4 percent) indicated that without professional help the person described in

Table 19: Vig.1.(Paranoia). Recovery without and with professional help compared by group.

		Old.Ads.		Yng.Ads.	
		no.	%	no.	%
without prof. help	REC.COMP.	2	8	1	3.6
	REC.RECUR	7	28	6	21.4
	REC.SIGNS	9	36	8	28.6
	NEV.REC.	7	28	13	46.4
with prof. help	REC.COMP.	5	20	3	10.7
	REC.RECUR	15	60	5	17.9
	REC.SIGNS	5	20	20	71.4
	NEV.REC.				

without professional help... chi = 2.1060 df = 3 p = .5507
with professional help... chi = 14.3763 df = 2 p < .0008***

*** denotes significance at the p < .001 level.

the vignette would 'never recover' whilst with professional help this changed to a majority (71.4 percent) who chose recovery with signs of having had the problem. The difference between the groups' responses in the condition, with professional help, was significant at the p < .001 level.

Table 20: Vig.2.(Alcoholism). Recovery without and with professional help compared by group.

		Old.Ads.		Yng.Ads.	
		no.	%	no.	%
without prof. help	REC.COMP.	2	8	1	3.6
	REC.RECUR	12	48	16	57.1
	REC.SIGNS	8	32	5	17.9
	NEV.REC.	3	12	6	21.4
with prof. help	REC.COMP.	12	52.2	11	39.3
	REC.RECUR	6	26.1	6	21.4
	REC.SIGNS	5	21.7	11	39.3
	NEV.REC.				

without professional help... chi = 2.4351 df = 3 p = .4871
with professional help... chi = 1.8208 df = 2 p = .4028

In relation to the 'alcoholism' vignette, Table 20 shows that most older and younger adults considered recovery with recurrence as the likely outcome when there was no professional help (48 percent and 57.1 percent respectively). When there was professional help most older adults (52.2 percent) indicated complete recovery whilst younger adults were divided for the most part between those who indicated complete recovery (39.3 percent) and those who indicated recovery but with signs of having had the problem (39.3 percent). There were no statistically significant differences between the groups on this vignette.

In relation to the 'phobia' vignette, Table 21 shows that in the absence of professional help a majority of older adults considered recovery with recurrence as the most likely outcome. With professional help this was still the most common choice of outcomes (37.5 percent), however 33.3 percent indicated complete recovery which had not been indicated at all when there was no professional help. The larger part of the younger adults sample (32.1 percent) indicated recovery with recurrence as the likely

Table 21: Vig.3.(Phobia). Recovery without and with professional help compared by group.

		Old.Ads.		Yng.Ads.	
		no.	%	no.	%
without prof. help	REC.COMP.			3	28.6
	REC.RECUR	10	40	8	32.1
	REC.SIGNS	9	36	9	28.6
	NEV.REC.	6	24	8	10.7
with prof. help	REC.COMP.	8	33.3	14	50
	REC.RECUR	9	37.5	2	7.1
	REC.SIGNS	6	25	12	42.9
	NEV.REC.	1	4.2		

without professional help... chi = 3.3489 df = 3 p = .3409
with professional help... chi = 8.8355 df = 3 p < .0316*

* denotes trend at the p < .05 level.

outcome in the absence of professional help. This changed to 50 percent favouring complete recovery when professional help was available. The difference between the groups' responses for this problem, with professional help, showed a trend approaching significance.

In relation to the 'depression' vignette, Table 22 shows that a majority of older adults (48.5 percent) considered recovery with signs of having had the problem as the most likely outcome in the absence of professional help. With professional help, this changed to a majority (44 percent) who indicated complete recovery. The larger number of younger adults (57.1 percent) indicated recovery with recurrence without professional help and recovery with signs of having had the problem (53.6 percent) with professional help. The difference in the groups' responses, in both the without and with professional help conditions, were approaching significance (without prof. help, $p < .0155$; with prof. help, $p < .0394$).

In relation to the 'dementia' vignette, Table 23 shows that, in the absence of professional help, a majority of both older and younger adults (68 percent and 89.3 percent) considered the person described as likely to never recover. With professional help the size of the majority of older adults who consider that the person described will never recover decreased to 47.8 percent. This was still the most commonly chosen outcome for the older adults sample. The younger adults figure dipped a little from 89.3 to 82.1 percent. There were no statistically significant differences between the groups for this vignette.

Table 22: Vig.4.(Depression). Recovery without and with professional help compared by group.

		Old.Ads.		Yng.Ads.	
		no.	%	no.	%
without prof. help	REC.COMP.	4	16.7	5	17.9
	REC.RECUR	9	35.7	16	57.1
	REC.SIGNS	11	48.5	3	10.7
	NEV.REC.			4	14.3
with prof. help	REC.COMP.	11	44	8	28.6
	REC.RECUR	9	36	5	17.9
	REC.SIGNS	5	20	15	53.6
	NEV.REC.				

without professional help... chi = 10.3964 df = 3 p < .0155*
with professional help... chi = 6.4675 df = 2 p < .0394*

* denotes trend at the p < .05 level.

There was therefore, only limited support for Hypothesis (ix), with a significant difference for the 'paranoia' vignette with professional help, and differences showing a trend towards significance for the 'phobia' vignette with professional help and the 'depression' vignette both without and with professional help.

Table 23: Vig.5.(Dementia). Recovery without and with professional help compared by group.

		Old.Ads.		Yng.Ads.	
		no.	%	no.	%
without prof. help	REC.COMP.	2	8		
	REC.RECUR	1	4		
	REC.SIGNS	5	20	3	10.7
	NEV.REC.	17	68	25	89.3
with prof. help	REC.COMP.	1	4.3		
	REC.RECUR	5	27.1	2	7.1
	REC.SIGNS	6	26.1	3	10.7
	NEV.REC.	11	47.8	23	82.1

without professional help... chi = 4.8696 df = 3 p = .1816
with professional help... chi = 7.0991 df = 3 p = .0688

HYPOTHESIS TEN.

This hypothesis addressed the sources which participants cited their ideas and views as having come from. Participants were offered a range of sources to mark when relevant. These were: radio or T.V., newspapers and magazines, books, discussions with family/ friends/ workmates, general education, their GP, from contact with psychiatrists, with psychologists, with counsellors, with other mental health professionals and 'other'. With the exception of GP as source, which was not marked by any of the older adults and by only one of the younger adults, all of the

Table 24: Sources cited compared by group.

	Old.Ads.		Yng.Ads.		chi	df	p
	no.	%	no.	%			
Rad.tv.	9	36	22	78.6	9.8590	1	.0017**
Newsp.mag.	12	48	19	67.9	2.1450	1	.1430
Books	13	52	15	53.6	.0131	1	.9090
Disc.fam.fri.wrk.	16	64	26	92.9	6.6871	1	.0097**
Gen.ed.	13	52	19	67.9	1.3882	1	.2387
GP			1	3.6	.9100	1	1.0000
Psychiat.	6	24	1	3.6	4.8083	1	.0430*
Psychol.	5	20	3	10.7	.8886	1	.4527
Couns.	8	32	5	17.9	1.4271	1	.2322
Oth.M.H.Prof.	2	8	2	7.1	.0139	1	1.0000
Other	12	48	7	25	3.0381	1	.0813

nb: * denotes trend at the p < .05 level

** denotes significance at the p < .01 level.

available sources were marked as relevant by some older and some younger adults. As can be seen from Table 24, there were two statistically significant differences between the groups. Twenty-two younger adults (78.6 percent) cited radio and t.v. as a source for their views and ideas as opposed to nine older adults (36 percent). This was significant at the p < .01 level. Twenty-six younger adults (92.9 percent) cited discussions with family, friends and workmates as a source for their views and ideas as opposed to sixteen older adults (64 percent). This was significant at the p < .01 level. Six older adults (24 percent)

cited contact with psychiatrists as a source for their views and ideas as opposed to one younger adult (3.6 percent). This result demonstrated a trend towards significance. Participants who cited the nature of 'other' when they marked it, generally referred to their own personal experience or that of people around them. One older adult cited her attendance at workshops on alternative therapies and stated that she considered these to be more helpful than the orthodox approach. Therefore, Hypothesis (x) was supported.

SUMMARY.

Hypotheses (i), (ii), (v) and (vi), relating to recognition, interpretation, seriousness and help / treatment were not supported by the data. Hypothesis (iii), addressing differential use of causative constructs in relation to specific problems, received limited support, with significant differences in relation to 'alcoholism' and 'dementia', and differences demonstrating a trend towards significance for 'paranoia' and 'depression'. Hypothesis (iv), addressing differential use of causative constructs for the problems taken as a whole, was supported in relation to the construct 'difficulties in personal relationships'. Hypothesis (vii), addressing source of help, was not supported, although there was a difference which revealed a trend approaching significance for 'dementia' in relation to professional help. Hypothesis (viii), addressing need for inpatient treatment, was supported in relation to 'paranoia', 'alcoholism' and 'dementia'. Hypothesis (ix), addressing

recovery, was supported in relation to 'paranoia' with professional help, whilst trends approaching significance were found for 'phobia' with professional help, and 'depression' both without and with professional help. Hypothesis (x), addressing source of views and opinions, was supported.

DISCUSSION

ISSUES OF METHODOLOGY.

This research endeavoured to generate results which represented views and ideas held by ordinary people which could be generalised to wider society and, in particular, looked at the differences between people within an older age range as compared to those of a younger age group. There are clearly some reservations which must be acknowledged when attempting to generalise outwards in this manner. The sample size was small (53 people) and smaller still when broken down into constituent groups (25 older adults and 28 younger adults). The representativeness of this sample must therefore be viewed as limited and would have been enhanced by a larger sample.

As the rationale behind the current research was the potential for meaningful differences between different samples of the general public it has to be recognised that variables other than age may also be important. The general public are not a homogenous population. In an attempt to rule out gross differences between the samples on variables other than age, preliminary analyses were conducted on a number of demographic factors. It was gratifying to find that there were no statistically significant differences between the groups in terms of gender or social class, as based on occupation, or in terms of personal experience of the problems presented.

There were significant differences between the groups in terms of marital status and education. Older adults were mostly married, widowed or separated, whilst younger adults were mainly single with the remainder cohabiting. Far fewer older adults than younger adults (a little less than half) had attended some form of tertiary education. Whilst it is plausible to argue that these differences are possibly valid representations of reliable demographic differences between older and younger adults, they cannot be ruled out as important or influential variables in their own right. A more rigorous approach could have demanded matching across these demographic variables to demonstrate the independent power of age as a variable. However, attention would have to be paid to not losing external validity through comparing samples which were not truly demographically representative. It should also be acknowledged that age range bands were not equivalent between the groups in the present research. As it transpired, the older adults occupied a range of 27 years as opposed to just 9 years for the younger adults. Thus, it cannot be argued that a comparison was made of two cohorts (a cohort being a group of people born at around the same time and hence experiencing some equivalence of culture and macro-social events) but rather of one younger cohort and at least two older cohorts.

Problems were encountered with gaining access to samples. As was seen, for reasons not ultimately clear, the original formal approach to companies to gain access to their workforces (for younger adults) was not fruitful and a networking approach was introduced. This did, arguably, produce the benefit of a wider distribution of participants in terms of location and occupation.

The older adults were sampled from two main sources, 'drop in' centres and a lecture/discussion society. Whilst it was helpful to draw on two clearly different types of setting where older adults congregate for different purposes, there may have been biases implicit to these different sources which distinguish them from the wider older population. A larger piece of work might have benefitted from a more readily generalisable form of sampling, such as might be based on the electoral register or the telephone directory, although it could also engender biases of its own.

One clear bias across the groups as a whole was their (unintended) uniform ethnicity (i.e. white). Whilst this undoubtedly limited the current research in one sense, it should be remembered that ethnicity and culture have been reported as important factors in their own right and that, at the very least, ethnicity would have to be proportionate across the groups if there were to be confidence in the current findings. Possibly the current sample could act as a reference point for future comparisons on the basis of race and culture.

As alluded to before, there were some difficulties with recruitment, not only on the large scale but also on an individual level. Whilst some of the factors (e.g., concern about the nature of psychological research) may have operated on both levels, others may have been more specific. For instance, relatively long periods of time were spent at the drop in centres relative to the number of older adults who were recruited. It may be that the size and time commitment of the questionnaire were off putting. Unfortunately, whilst reducing the size of the

questionnaire might have given a pay off in terms of increased sample size, it would have necessitated a cost in terms of scope either in relation to the range of problems addressed or the range of questions relating to each problem (and hence affect content validity).

Most people who did participate found the questionnaire acceptable and only one participant (a younger adult) wrote at the end that they found the wording too opaque. Non-literate individuals were likely to have excluded themselves and this may not be unimportant in terms of implications. For example it might lead to greater reliance on certain sources of information and potential differences in subsequent implicit models. (Although in one instance the researcher went through the questionnaire with an older adult, reading it to her, so as not to exclude her for this reason.) A number of questions and their respective choice of answers were found to be a little less straightforward than the piloting procedure had suggested. Specifically, a number of participants expressed uncertainty about the wording of questions 7 and 8 and were unsure about the extent to which 'family and friends' and 'professional help' were supposed to be additive or mutually exclusive. Furthermore, the wording on question 10 in relation to the 'dementia' vignette was, with hindsight, unsatisfactory because it mixed together the concepts of need for hospitalisation and recovery. A number of participants commented on this and clearly the findings in response to this question must be considered equivocal.

A further criticism which could be directed toward the present design concerns the presentation of preconceived constructs in

questions 2a and 3. As Schuman and Presser (1979) illustrated, closed response forms of this kind are likely to differ from open responses unless the choice of closed end constructs is derived from previous qualitative research. This was the case in the present research, as the constructs offered were derived from the qualitative work of Barry and Greene (1992). However, Barry and Greene's work was conducted in another country with a different culture. It is clear that the validity of the current research would have been enhanced if open responses had been invited in response to these questions which would then be available for subsequent coding. Failing this, it might have been appropriate to offer an 'other ... please describe' factor to participants when a range of options were presented.

The weighting scheme for the causative factors in question 3 might also be questioned. There was a four point weighting range with a difference of one point between those factors actively excluded and those simply left unmarked. Similarly a one point difference was gained in the move from being left unmarked to being ranked as third most important. Whether this objective weighting scheme reflected the participants' subjective weighting of causative factors is, of course, debatable. The order of importance was, however, valid and correct.

DISCUSSION OF RESULTS.

Older and younger adults did not significantly differ with regard to the extent to which they recognised the case descriptions as problems. Recognition rates were high, ranging generally from the eighties to one hundred percent. The

'dementia' vignette was the problem least recognised as such, at 88 percent for older adults and 78.6 percent for younger adults. Similarly, there were no significant differences between the groups with regard to their interpretation of the problems as pathological, characterological (personality based), or situational. The majority of participants agreed in their interpretations that 'paranoia' and 'dementia' were pathological, and that 'phobia' and 'depression' were situational. Most older adults considered 'alcoholism' to be a characterological problem (most younger adults considered it situational), but as stated this difference was not statistically significant and so could have occurred by chance.

When participants were asked to identify the causative factors which they thought most important, it appeared that, as with Barry and Greene's (1992) sample, they considered problems on a case by case basis and explained each in a specific (if eclectic) rather than generic fashion. Whilst all factors received some support in every case, a range of factors came up as most important. Interestingly, in the light of the previously described assumptions that older adults have a limited understanding of mental disorder, it was a wider range for older adults. The current data would also seem to support the idea that the use of the label 'mental illness' cannot be taken a priori to mean that participants prioritise somatic factors as the basis for a problem. Whilst this was the case for 'dementia', it was not for 'paranoia'. The most important factor for older adults in explaining 'paranoia' was childhood experience, whilst for younger adults it was personality and cognitive style. Furthermore, problems which were interpreted as situational such

as 'alcoholism' and 'phobia' for younger adults, and 'phobia' for older adults, were considered as having personality and cognitive style as the primary causative factor, although other more situational/ reactive type factors were also weighted heavily. These findings suggest that people may be operating relatively sophisticated interactive models of mental disorder whose complexity will not be revealed through superficial questioning.

Although Barry and Greene's (1992) research did not allow for the weighting of causative factors in the same manner as the current work, the designs are similar enough to allow for some comparison. The counts of most frequently verbalised explanations tended to differ from the current results, perhaps most strikingly in relation to 'alcoholism'. In Ireland this problem was explained most frequently by reference to somatic factors. Older and younger adults in the current sample weighted biological/physiological factors as equal least, and least important. Personality, which was the second most frequent basis for explanations in Barry and Greene's sample was, however, weighted most heavily by the present younger adults and as the second most important factor by the current older adults. Similarly, whilst most of the explanatory statements generated in response to the 'phobia' vignette by Barry and Greene's sample came in the category of childhood problems, this factor was weighted as second and third most important by the present older and younger adults. Whilst comparisons are difficult, in view of the differing methodologies, they would seem to support the view that implicit models will vary, in ways which can be subtle or major, across communities and cultures.

Further analyses would have allowed for comment on how meaningful the differences within the groups might be. However, the current research was concerned with identifying the differences between the groups. A number of statistically significant differences, and trends approaching significance, did arise, although none were on factors weighted as either most or least important in relation to any of the case descriptions. This shows, not only the inherent weakness in attempting to delineate implicit models by looking at the polarity of most and least important factors, but also emphasises the epistemological importance of middle ranking factors as structurally important agents within sophisticated models of mental disorder.

There was a trend to suggest that older adults may rate as less important the role of personality and cognitive style in relation to 'paranoia'. Older adults rated as less important the role of social situation/circumstances in relation to 'alcoholism'. There were trends to suggest that the older adults' higher rating for difficulties in personal relationships, and younger adults' higher rating for stress and pressure, both in relation to 'depression', may be meaningful. In relation to 'dementia', older adults rated as more important the role played by stress and pressure, whilst younger adults rated as more important the role of somatic factors.

These differences, and possible differences, whilst subtle in as much as they did not relate to those factors considered to be most important, may nonetheless have some clinical implications. These will be considered in the next section. What is important to note at this point is that the only significant difference

between the groups in the weight given to somatic factors was for 'dementia' and that it was younger rather than older adults who accentuated its importance, which does not fit with the notion that older adults view (at least these) mental disorders from a more somatically oriented framework. Hasin and Link's (1988) finding that older adults view depression within a more somatically oriented framework was not supported here. As well as not being significantly differentiated between the groups, it was the second least important factor for both groups. Hasin and Link's vignette describing 'depression' appeared to feature biological symptoms prominently (e.g. appetite and weight loss, disturbed sleep) and it may be that their older sample were more cue-dependent in their responses (or alternatively that as a finding it is simply not generalisable to a different cultural and time setting). The vignette describing 'depression' (Barry, 1991) used in the present research appears more broadly descriptive and hence, in the view of the present researcher, to have greater face validity and perhaps be less 'leading' in terms of likely responses. Again, it is important to note that when Ogden (1990) investigated the models of depression held by older people (in this country) who were actually suffering from depression, her findings did not support Hasin and Link's position.

Whilst recognising the distinctiveness of implicit 'sense-making' in relation to different problems, consideration of the use of the different causal factors in relation to the vignettes taken as a whole can be instructive in what it suggests about the styles of 'sense-making' or understanding that older and younger adults adopt overall. A remarkable degree of similarity was

evident. Both groups adhered to the same top three and bottom three factors. For both older and younger adults stress and pressure, personality and cognitive style and somatic factors were most important. Both groups rated somatic factors as third in this ordering whilst stress and pressure were most important for older adults and personality and cognitive style were most important for younger adults. This would suggest that somatic factors were considered to be important by older and younger adults, but not as important as stress and pressure or personality and cognitive style. Similarly, for both groups, the bottom three factors were difficulties in personal relationships, childhood experience and social situation/circumstances. Whilst difficulties in personal relationships was rated as the fourth most important factor by older adults, it was rated as least important by younger adults. This was a statistically significant difference. The differences between the groups for somatic factors (i.e. biology/physiology) and indeed the other factors, such as there were, were not statistically significant.

These results suggest that older adults are at least as sophisticated as younger adults in their general styles of 'sense-making' of mental disorder; that with the exception of an increased emphasis on relationship factors by older adults these styles are very similar and that, whilst somatic factors are important for both groups, stable features of personality combined with situational stress are more important. If the 'dementia' vignette, arguably more recognisable as 'biological' in nature, were removed from the equation, the influence of somatic factors would have possibly slipped in importance. Furthermore, if 'psychological mindedness' is equated with

demonstrating a full and broad understanding of the role and functions that a range of psychosocial factors play in mental ill-health, then the current findings offer no support for the view that older adults are less psychologically minded than younger adults. The clinical implications of these findings are addressed in the following section.

In relation to seriousness, both groups considered 'paranoia' to be most serious and 'phobia' to be least serious. There were no statistically significant differences between the groups for any of the problems. Ratings of perceived need for help were high. The lowest ratings for both groups related to 'dementia', but large majorities of both groups still thought that the person in the vignette needed help. There were no statistically significant differences between the groups in relation to this question.

Similarly there were no statistically significant differences between the groups in terms of the extent to which they saw 'family and friends' as the appropriate source of help. At least half of each sample agreed to this proposition in relation to 'depression' and 'dementia', while at least half the younger adults agreed in relation to 'phobia' and at least half the older adults in relation to 'alcoholism'. Less than half of both groups agreed to this proposition in relation to 'paranoia'.

A majority of participants in both groups agreed that professional help was necessary for all the problems presented. There was one trend towards significance, more older adults (90%) than younger adults (60%) indicated this necessity in relation

to 'dementia'. Most older and younger adults did not think that inpatient psychiatric treatment would be necessary for all the problems described with the exception of 'paranoia' where a majority of older adults (70.8%) thought that it would be. This difference was statistically significant. Two other significant differences were apparent. Whilst a minority (25%) of older adults thought that inpatient treatment would be necessary for 'alcoholism' and 29.2 percent thought that it would be necessary for 'dementia', no younger adults agreed. Thus, it would appear from the present findings that older adults do have different implicit models of mental disorder from younger adults when it comes to the issue of need for inpatient treatment in relation to certain problem presentations (and possibly need for treatment in relation to 'dementia'). The clinical implications of these findings will be discussed in the next section.

Responses to questions concerning recovery were reassuring, in that, whereas the people described in all the vignettes were considered by some, at least, from each group as likely to never recover, when professional help was available this shifted (except in the case of 'dementia') to partial or complete recovery (although there was one older adult who pessimistically stood by 'never recover' in relation to 'phobia'). There was one statistically significant difference between the groups and three findings which suggested a trend towards significance. The significant finding was on the 'paranoia' vignette with professional help, whilst the trends approaching significance were found in relation to the 'phobia' vignette with professional

help, and the 'depression' vignette both without and with professional help.

The findings are perhaps difficult to interpret, however, as they seemed to reflect some differential use of the two intermediate recovery stages of 'recovery with recurrence' and 'recovery with signs'. There was also some suggestion (although non-significant) that younger adults were more pessimistic about the 'depression' vignette when professional help was not available and that older adults were more optimistic when it was. Again, this rather curious finding is difficult to interpret, although it may suggest that older adults viewed the problem as less fixed and more amenable to help.

The final area examined was the sources participants cited their views and opinions as coming from, which might reflect the different cultural factors operating for older and younger adults. Significantly more younger adults than older adults cited radio and TV as a source (78.6% as opposed to 36%). They also drew to a significantly larger degree on discussions amongst family, friends and workmates (92.9% as opposed to 64%). This would seem to suggest that older adults either developed their ideas at a time before psychological and mental health issues became 'popularised' (cf Knight, 1986) by the media or that they do not attend to such programmes when they appear. The latter possibility might relate to the difference between the groups in terms of discussions with family, friends and workmates. This difference suggests that mental disorder may be a taboo issue for older adults.

What is interesting is that despite these two findings, older and younger adults' implicit models of mental disorder were highly comparable. The one source which notably more older adults cited (and this difference demonstrated only a trend towards significance and hence may have occurred due to chance) was contact with psychiatrists (24% as opposed to 3.4% of younger adults). The psychiatric nature of mental health provision for older adults in the present day and for all individuals to some extent historically, combined with more years of life in which to encounter psychiatry, may account for this difference (if indeed it is a real difference). What remains apparent is that it hasn't led to an increasingly psychiatric (in the narrow sense of biological) framework for understanding mental disorder. Not all psychiatrists are un-psychological in their own view-points and it may be that older adults have not received overly biological orientated communications concerning the problems which presumably either they or their close ones have presented with. Alternatively, if older adults have received these types of communication, they would appear not to have been incorporated into their own implicit models. As Weinstein and Brill (1971) found out, psychiatric treatment can be associated with a rejection of the narrow psychiatric model by patients. If ordinary people in the psychiatric system do find themselves being confronted with a model which they do not accept, then this might explain Hall et al.'s (1993) finding that recipients of psychiatric treatment are less likely to subsequently cite psychiatrists as a source of help than people who haven't come into the system.

CLINICAL IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH.

There are clinical implications contingent upon the implicit models of mental disorder that clients bring with them when they meet a mental health practitioner for the first time. As Nations, Camino and Walker (1988) pointed out, communication can be impeded when lay illness labels and metaphors are not understood as distinct from, rather than pale imitations of, clinical terminology. Winter (1985) has argued that creating a match between therapists and clients in terms of their predominant constructions of reality can be important, especially in relation to preventing people from dropping out from therapy. Furthermore, Norman and Malla (1983) have suggested that a stronger belief in psychosocial aetiology will lead to a greater optimism about treatment and prognosis. As Barry (1991) pointed out, beliefs about the nature of mental disorder may not only affect individual treatments variables, but will also have wider service implications for the development of community, rather than asylum-based, services for the mentally ill.

If apparent differences in mental health care provision for older adults are based upon a notion that they are in some sense less psychologically minded than younger adults then the findings of the current research would suggest that these service differences may well be based on a false premise. Older adults in the current sample employed a range of psychosocial factors to explain examples of mental disorder and were remarkably similar to younger adults in the manner in which they did so.

Clearly these results can help those who wish to argue for more comprehensive, psychologically orientated services for older adults. More specific implications relevant to the different forms of psychological therapy may also be apparent. For instance, it is often argued (e.g. Bradbury, 1991) that older adults may fare better with more present-oriented and practical approaches such as cognitive behavioural therapy than with those such as the psychodynamic which stress the importance (at a theoretical level at least, if not always so actively in therapeutic interactions) of childhood experience. Whilst it is true that older adults, in their general style of making sense of the descriptions of mental disorder, did emphasise current issues such as stress and personality rather than childhood experience, this was equally true of younger adults. Attempts to focus service thinking towards the ways in which psychodynamic approaches can be utilised with older adults (e.g. Ogden, 1993) are, therefore, very welcome.

Another thought provoking finding was that older adults lay an increased emphasis on the role of difficulties in personal relationships in the creation of mental health problems. This perspective may augur well for the utility of couple therapy and indeed for systemic work generally, such as the, as yet small but increasing, provision of family therapy services for older adults and their relatives (e.g. Gilleard, Lieberman and Peeler, 1992).

The differences specific to the individual problem vignettes may also be useful pointers to potentially mismatching models for psychological problems. For instance, older adults were less accepting of the role of social factors in relation to

'alcoholism' than younger adults and indeed probably less accepting than much of professionals' current thinking in this field (e.g. Cook, 1994). Other findings were generally only trends, but might be worthy of attention if only to alert the practitioner to the potential for differing models.

The findings in relation to 'dementia' were of interest. Less older adults thought that what the vignette described was necessarily a problem, although more (admittedly at the trend level) proposed that professional contact was needed. Whilst both groups understood the problem, primarily, from a biological point of view, younger adults did so to a significantly greater degree, whilst older adults accorded a role to stress/pressure which younger adults did not allow. A superficial view of these findings might lead one to believe that (at least some) older adults were defending against thinking about the realities of the biological brain disorders which they are at an increased risk of experiencing. However, another possibility is that older adults (accurately) recognised that the un-named problem could be caused by a range of physical aetiologies, saw a greater need for investigation, and understood, furthermore, that other, environmental, factors may play an important role in 'dementia' type processes. (This last idea is one which is gaining increasing prominence in the professional world, e.g. Kitwood, 1993).

The question which remains is one of why, if older adults are receptive to psychological and psychosocial thinking, is there a perception that older adults are reluctant to seek mental

health care (e.g. McQuellon and Riefler, 1989). Three reasons present themselves in response to this question.

Firstly, as already noted, older adults receive services in which the medical model predominates, (see also Gelder et al., 1989). On the basis of the current findings this explanatory framework will not match the broader bio-psychosocial frameworks which older people operate. This may go some way to explaining the unattractiveness of mental health services. Secondly, although the current findings suggest that older adults are comparably optimistic with younger adults about the efficacy of professional help, it was apparent that significantly more considered hospitalisation as a likely part of that treatment in relation to three of the vignettes (paranoia, alcoholism and dementia). This belief is understandable in the light of historical trends of mental health care. A government report in 1972 (DHSS, 1972) drew attention to the fact that many older psychiatric patients had been admitted before modern treatments were available and had consequently grown old in hospital. Older adults may resist contact with mental health services if they believe that they will be hospitalised, possibly permanently.

Thirdly, the current findings do suggest that mental ill-health may be a taboo topic for older adults, neither discussed openly nor attended to when in the media. This may be a more real cultural difference between older and younger adults than others which have been suggested. Bradbury (1991) proposed that older people may carry with them something of the 'stiff upper lip'

ethos which may mean that to admit to distress and dysphoria is seen as shameful or weak. Which of these or other factors may be important is an area worthy of further research.

Other areas which could usefully be investigated further include a more in depth enquiry into how people (including older people) develop their implicit models and an examination of their durability. Further examination of the processes of mutual construction of problems between therapists and clients would also be desirable as would an examination of what happens when this process starts with conflictual models. Perhaps, even more importantly, we may need to look more closely at our own professional perspectives on aging to ensure that social or cognitive biases do not stymie our understanding of older adults nor jeopardise their right to comprehensive care.

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LIST OF APPENDICES.

APPENDIX 1

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

22nd April 1996

SALOMONS CENTRE

Dear Sir or Madam,

I am a Psychologist in clinical training on a doctoral programme within the National Health Service. I am interested in investigating how people from the general public and of different age groups view and make sense of certain psychological problems at a stage before they seek professional help. This sort of information is at present under researched and could be of some importance to the planning and provision of future counselling and mental health services.

I am particularly interested in accessing the views and opinions of a sample of older adults (i.e. over 65) as their perspective can often be passed over when mental health and counselling services are being developed. I am contacting you because I live locally and have noticed that you run an over 60's club at your new social centre. I am wondering whether you would be willing to let me come along, explain what I am doing and invite people to take part.

Participation is, of course, entirely voluntary and merely involves completing a questionnaire, with me present. This can be done individually or in small groups. The information would be entirely confidential and the individuals names would not be recorded on their questionnaire. The questionnaire is not

invasive of peoples privacy and the procedure has been passed by an Independent Expert Ethics Committee.

I recognise that you would probably like to know more and perhaps even see the questionnaire before you make your decision. As I say, I live locally (on Albury St.) and can very easily visit to explain things further. I recognise that you may be busy but hope that you will give my request your consideration. The results will help with the future planning of counselling and mental health services in the National Health Service, especially with regard to older people and is therefore, I believe, quite important.

If you feel that you would like to help or alternatively that you do not you can write to me at either the address at the top of the page or my home address, 28 Albury St. Alternatively you could leave a message for me with Lynda Thompson (research administrator) by calling the 'phone number at the top of the page.

I look forward to hearing from you.

Yours sincerely

Hedley Harnett

Psychologist.

The Salvation Army

United Kingdom Territory
with the Republic of Ireland

Deptford Community Centre

Mary Ann Gardens, Deptford,
London, SE8 3DP.
Telephone: 0181-692 5263

9th. May, 1996.

Hedley Harnett,
28, Albury Street,
Deptford.

Dear Hedley,

Thank you for your letter requesting visiting our Centre to speak with the older folk who come to us on a daily basis.

We shall be quite happy for you to visit and share with the folk. Our Over 60's Club meet on a Wednesday morning 10.45-11.45a.m. They usually have a cup of tea first, but there will be time for you to speak with them, and we can alter the starting time a little if necessary. We can discuss this with you when we arrange a date for you to come.

I suggest you contact us in order to arrange a date, Looking forward to meeting you.

Yours sincerely,

Pamela J.Saunders.
Major.

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS
CENTRE

15 th May 1996

Hedley Harnett

Psychologist in clinical training

28 Albury St.

Deptford.

Tel.: 0181 691 6523 (answer machine 9-5)

Dear Major Saunders

Thankyou for your kindness in so promptly responding to my enquiry.

If it is acceptable to you, I should like to come along to your Wednesday Over 60's Club next wednesday - the 22nd. This first visit would allow me to distribute the information sheets (I've enclosed one for you to look at!) which I like people to have a chance to look at before taking part. It might be helpful for me to very briefly say who I am and what the sheets are, before handing them out. This would not take much time at all. People can then take the sheets home and have a good read. Then (again, if this is acceptable to you) I could return the wednesday after that - the 29th - and those people who wanted to participate could fill in the actual questionnaire. No interviews or such like are required, the questionnaire takes between 20 and 30 minutes and people can do them at the same time.

It may not be necessary for me to interupt the time, certainly for the first visit. I am happy to fit in with whatever you think best and could come either at the beginning or at the end ?

I'll contact you on the phone in the next couple of days to see what you think.

Thankyou again

Best Wishes

Hedley Harnett
Psychologist in clinical training.

APPENDIX 2

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS
CENTRE

7th May

Dear

I understand from Ann Hemsley that you may be willing to take part in some psychological research by filling in a questionnaire. I enclose an information sheet which explains what it is about. I shall be coming to the Parkview Resource Centre on Friday the 10th at midday when hopefully I shall be able to catch you after your talk. I look forward to meeting you.

Yours sincerely

Psychologist.

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS CENTRE

1st March 1996

Dear Sir or Madam,

I am a Psychologist in clinical training on a doctoral programme within the National Health Service. I am interested in investigating how people from the general public and of different age groups view and make sense of certain psychological problems at a stage before they seek professional help. This sort of information is at present under researched and could be of some importance to the planning and provision of future mental health services.

I am at present attempting to access a sample of younger adults (ie from 18 - 30) who would be willing to participate by completing a questionnaire, with me present. This could be done individually or in small groups. The information would be entirely confidential and the individuals names would not be recorded on their questionnaire forms. The questionnaire would probably take between 15 and 30 minutes at most to complete.

It is on this basis that I am approaching you to see whether you feel that your organisation would like to be involved in this project. I recognise that in this day and age time is at a premium but hope nonetheless that you would still like to participate. The findings may be of some value within the

National Health Service. The likelihood is that they will also be published in a scientific journal and I would of course wish to acknowledge your assistance if you decide that you would like to take part. My research protocol (procedure) is at present being formalised by a National Health Service Ethics Committee.

I am of course very happy to discuss the project further with you if you would like, before you make your decision. The numbers of participants I require is really quite small.

Looking forward to hearing from you.

Yours sincerely

Hedley Harnett
Psychologist.

APPENDIX 4

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS CENTRE

2nd April 1996

Dear Sir or Madam,

I am writing to you in connection with my previous letter dated 1st March. I am reluctant to add to what I know must be a busy schedule for you, but I realise that my letter may have gone astray (ergo copy enclosed) and so I am writing to call on your goodwill (and interest hopefully) once again. It may be that my previous letter is currently receiving attention, however, and if this is the case I'd like to add some pertinent information to it.

In addition to the detail provided in the first letter, you may wish to be assured that the questions in the questionnaire are not invasive of peoples privacy and that the procedure has been passed by an Independent Expert Ethics Commitee. The results will be of value within health and counselling services and I would of course provide you with a formal report on the findings (based on yours and other participant groups) should you elect to participate, as a way of demonstrating gratitude.

It may be that you have concerns with regard to the amount of time this procedure would take away from your organisation. I am of course keen to minimise disruption and could see volunteers

in their lunch breaks. With regards to location, any relatively quiet space (even a canteen) would suffice. I could provide a poster in advance for recruitment purposes and would visit for as few as five participants.

I am very happy to discuss any concerns or queries you have and will 'phone you on Friday the 12th April. I look forward to talking with you. If you wish to contact me in the meantime, please do so on the number at the top of the page (messages can be left with Lynda Thompson, research administrator). If you do not feel able to participate it would be very helpful for me to know this.

Yours gratefully,

Hedley Harnett
Psychologist.

APPENDIX 5

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS CENTRE

Head of Personnel

Lewisham Direct Team

London Boro' of Lewisham

Lewisham Town Hall

Catford Road

London SE6 4RU

22nd April 1996

Dear Sir or Madam,

I am a Psychologist in clinical training on a doctoral programme within the National Health Service and currently working at Lewisham and Guys Trust. I am interested in investigating how ordinary working people view and make sense of certain psychological problems at a stage before they seek professional help. This sort of information is at present poorly investigated and will be important in the planning and provision of future local mental health and counselling services.

I am at present attempting to access a sample of people aged from 18 - 30 who would be willing to participate in some research by completing a questionnaire, with me present. This could be done

individually or in small groups. The information would be entirely confidential and the individuals names would not be recorded on their questionnaire forms. The procedure has been passed by an Independent Expert Ethics Committee.

It is on this basis that I am approaching you to see whether you feel that your organisation would like to be involved in this project. What this would entail would be you allowing me access to your workforce. There is a variety of ways in which this could be done e.g. via staff meetings (if they occur) or I could canvass people in their canteens or staff rooms for their participation (which would of course be entirely voluntary). If you were to take part I would of course wish to ackowledge your assistance in the final report.

I recognise that in this day and age time is at a premium but hope nonetheless that you would still like to participate. I am of course very happy to discuss the project further with you if you would like, before you make your decision. The numbers of participants I require is really quite small. Furthermore in return for the small amount of time that I might take away from your organisation I am very happy to discuss with you ways in which I could contribute something in return. Besides giving you feedback on the overall results of the research and the implications that they hold with regard to your workforce I am

also happy to consider other possibilities - perhaps I could offer your employees a training session on 'stress management' or something similar ?

Looking forward to hearing from you.

Yours sincerely

Hedley Harnett
Psychologist.

P.S. Please feel free to leave a message for me with Lynda Thompson, research administrator, on the number at the top of the page.

APPENDIX 6

I'm thinking of a woman - let's call her Valerie Jones - who is very suspicious; she doesn't trust anybody, and she's sure that everybody is against her. Sometimes she thinks that people she sees on the street, are talking about her or following her around. A couple of times, now, she has attacked people who didn't even know her.
The other night, she began to curse her family terribly; then she threatened to kill them because, she said, they were working against her, too, just like everyone else.

Here's another person; we can call her Mary Brown. Most of the time she gets along alright with people, but she is always very touchy and she always loses her temper quickly if things aren't going her way, or if people find fault with her. She worries a lot about little things and she seems to be moody and unhappy all the time. Everything is going along alright for her, but she can't sleep at nights, brooding about the past, and worrying that things might go wrong.

How about Brenda Williams? She never seems to be able to hold down a job very long, because she drinks so much. Whenever she has money in her pocket, she goes on a spree; she stays out till all hours drinking and she is always the last to leave. She spends all her money on drink and never seems to care about anything else. Sometimes she feels very bad about this; she begs her family to forgive her and promises to stop drinking, but she always goes off again.

Now I'd like to tell you about another person - Patricia Lynch. She has an intense fear of closed spaces and would do anything to avoid going in an elevator. She often feels very uncomfortable in places such as in her local church or in the cinema. She begins to feel closed in, as if she cannot breathe, then she feels herself perspiring and her heart beginning to beat quickly. Sometimes she has had to leave when this happens and this causes her a lot of embarrassment. Once or twice now she was unable to go into church for services as she was afraid of how she might feel.

Let me tell you about Margaret Molloy. She can see no meaning in her life anymore, she sees herself as a failure and feels there is very little to look forward to. She finds it difficult getting up in the morning as the idea of facing another day often seems too much. Activities that she enjoyed in the past, she no longer finds interesting and she rarely bothers to go out anymore and meet other people. She often finds herself overcome with a feeling of sadness and can't stop herself from crying. Sometimes she thinks about ending it all as she feels it may be the only way out.

I'd like to tell you about Amanda Humphreys, a senior citizen. About a year ago she found that she was becoming somewhat absent-minded. More recently she became lost in the shopping centre and when she eventually found her way out she realised that she had forgotten what it was that she wanted to purchase. She finds it difficult to follow television programmes now and occasionally mistakes the next door neighbour for her son who lives in Bradford.

I'm thinking of a man - let's call him Colin Jones - who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has attacked people who didn't even know him.
The other night, he began to curse his family terribly; then he threatend to kill them because, he said they were working against him, too, just like everyone else.

Here's another person; we can call him John Brown. Most of the time he gets along alright with people, but he is always very touchy and he always loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things and he seems to be moody and unhappy all the time. Everything is going along alright for him, but he can't sleep at nights, brooding about the past, and worrying that things might go wrong.

How about Malcolm Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking and he is always the last to leave. He spends all his money on drink and never seems to care about anything else. Sometimes he feels very bad about this; he begs his family to forgive him and promises to stop drinking, but he always goes off again.

Now I'd like to tell you about another person - Richard Lynch. He has an intense fear of closed spaces and would do anything to avoid going into an elevator. He often feels uncomfortable in places such as his local church or in the cinema. He begins to feel closed in, as if he cannot breathe, then he feels himself perspiring and his heart beginning to beat quickly. Sometimes he has had to leave when this happens and this causes him a lot of embarrassment. Once or twice now he was unable to go into church for services as he was afraid of how he might feel.

Let me tell you about Peter Molloy. He can see no meaning in his life anymore, he sees himself as a failure and feels there is very little to look forward to. He finds it difficult getting up in the morning as the idea of facing another day often seems too much. Activities that he enjoyed in the past, he no longer finds interesting and he rarely bothers to go out anymore and meet other people. He often finds himself overcome with a feeling of sadness and can't stop himself from crying. Sometimes he thinks about ending it all as he feels it may be the only way out.

I'd like to tell you about Patrick Humphreys, a senior citizen. About a year ago he found that he was becoming somewhat absent-minded. More recently he became lost in the shopping centre and when he eventually found his way out he realised that he had forgotten what it was that he wanted to purchase. He finds it difficult to follow television programmes now and occasionally mistakes the next door neighbour for his son who lives in Bradford.

APPENDIX 1

Hedley Harnett
South Thames (Salomons) CPTS
Salomons Centre
Broomhill Road
Southboro'
Tunbridge Wells TN3 OTG

Tel.: 01892 515152 (clin.psy.dept.) or
0181 6916523 (home - answering machine)

Dear

Thankyou for being willing to help me develop measures for my research into the psychological mindedness of older adults. This should only take a few minutes. Please post the results back to me at the above address. I enclose a pre-paid envelope.

Please turn over to continue.

Thankyou again,

Yours sincerely,

Hedley Harnett
Psychologist in Clinical Training.

The following are descriptions of people who may or may not have mental health problems.

Would you please state whether you feel that they represent reasonable descriptions of the sorts of problems which are likely to be encountered by mental health clinicians.

Furthermore, would any of the descriptions warrant a psychiatric diagnosis ? If so, what do you feel would be most appropriate ?

I'm thinking of a man - let's call him Colin Jones - who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has attacked people who didn't even know him. The other night, he began to curse his family terribly; then he threatend to kill them because, he said they were working against him, too, just like everyone else.

REASONABLE DESCRIPTION? ☐ YES ☐ NO

(PLEASE TICK)

IF NO, WHY NOT? _____

_____

_____

_____

_____

DIAGNOSIS? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

Here's another person; we can call her Mary Brown. Most of the time she gets along alright with people, but she is always very touchy and she always loses her temper quickly if things aren't going her way, or if people find fault with her. She worries a lot about little things and she seems to be moody and unhappy all the time. Everything is going along alright for her, but she can't sleep at nights, brooding about the past, and worrying that things might go wrong.

REASONABLE DESCRIPTION? ☐ YES
☐ NO
(PLEASE TICK)

IF NO, WHY NOT? _____

_____

_____

_____

_____

DIAGNOSIS? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

How about Malcolm Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking and he is always the last to leave. He spends all his money on drink and never seems to care about anything else. Sometimes he feels very bad about this; he begs his family to forgive him and promises to stop drinking, but he always goes off again.

REASONABLE DESCRIPTION ? ☐ YES
☐ NO
(PLEASE TICK)

IF NO, WHY NOT ? _____

_____

_____

_____

_____

DIAGNOSIS ? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

Now I'd like to tell you about another person - Patricia Lynch. She has an intense fear of closed spaces and would do anything to avoid going in an elevator. She often feels very uncomfortable in places such as in her local church or in the cinema. She begins to feel closed in, as if she cannot breathe, then she feels herself perspiring and her heart beginning to beat quickly. Sometimes she has had to leave when this happens and this causes her a lot of embarrassment. Once or twice now she was unable to go into church for services as she was afraid of how she might feel.

REASONABLE DESCRIPTION ? ☐ YES ☐ NO

(PLEASE TICK)

IF NO, WHY NOT? _____

_____

_____

_____

_____

DIAGNOSIS ? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

Let me tell you about Peter Molloy. He can see no meaning in his life anymore, he sees himself as a failure and feels there is very little to look forward to. He finds it difficult getting up in the morning as the idea of facing another day often seems too much. Activities that he enjoyed in the past, he no longer finds interesting and he rarely bothers to go out anymore and meet other people. He often finds himself overcome with a feeling of sadness and can't stop himself from crying. Sometimes he thinks about ending it all as he feels it may be the only way out.

REASONABLE DESCRIPTION ? ☐ YES
☐ NO
(PLEASE TICK)

IF NO, WHY NOT ? _____

_____

_____

_____

_____

DIAGNOSIS ? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

I'd like to tell you about Amanda Humphreys, a senior citizen. About a year ago she found that she was becoming somewhat absent-minded. More recently she became lost in the shopping centre and when she eventually found her way out she realised that she had forgotten what it was that she wanted to purchase. She finds it difficult to follow television programmes now and occasionally mistakes the next door neighbour for her son who lives in Bradford.

REASONABLE DESCRIPTION ? ☐ YES
☐ NO
(PLEASE TICK)

IF NO, WHY NOT ? _____

_____

_____

_____

_____

DIAGNOSIS ? _____

(FILL IN ONLY IF YOU FEEL THIS PERSON WARRANTS A DIAGNOSIS)

Any further comments ?

Could you please state your professional status ? (e.g. clinical psychologist, senior registrar, psychogeriatrician, consultant psychiatrist etc.)

_____

A system for scoring similarity of responses was devised as follows:

There were four types of response format. Some questions allowed a forced choice from a pool of either two or three responses (Q.'s 1, 2a., 6, 7, 8, 10). For these questions answers were considered to be mutually exclusive and hence were scored as either 1 for same response or 0 for a differing response. One question (Q.3) offered paricipants the opportunity to rank a number of constucts. In the reliability test these constructs were taken individually. Participants were able to rank these constructs in one of three ways; they could assign a ranking of importance in causation for upto three constructs (i.e. 1st, 2nd and 3rd); they assign an 'x' if they considered the construct to play 'no part at all' in causation or they could leave construct with no label attached. This last option essentially meant that the construct was considered to have some low level causative role. Responses were coded as in agreement if in the first instance they were within one ranking point of each other (a '1' and a '2' were accepted as demonstrating a reasonable degree of agreement whilst a '1' and '3' were not). In the second instance constructs marked with an 'x' at the first sitting had to be followed by an 'x' at the later date for the responses to be accepted as being in agreement. Similarly an unmarked construct had to be similarly left unmarked at the second sitting to be scored as in agreement.

Two questions (Q.'s 4 and 5) offered a response pool of four options. For question 4 the responses 'very serious' and

'serious' were considered sufficiently coterminous to allow them to banded together for the purpose of gauging equivalence of resonse. Similarly the responses 'not so serious' and 'not at all' serious were coded as equivalent. For question 5 the responses 'a lot of difficulty' and 'some difficulty' were coded as equivalent as were the responses 'some difficulty' and 'not much difficulty'. The response 'no difficulty at all' was not considered to be broadly equivalent to any of the other possible responses. These codings were based on a subjective assessment arrived at in conjunction with the author's supervisor on the basis of face value semantics. Two questions (Q.'s 2b. and 9) offered respondents the opportunity to answer freely in one or a few words. Although it is a little unusual to code open responses in a similar manner, because of their brevity this was considered appropriate here. Question 2b. asked respondents to describe problems in their own words. Responses were coded as equivalent when they either reproduced at the second sitting a form of words communicating the same answer or the same core answer. For instance the following two responses from one individual in relation to the 'Alcoholism' vignette were coded as equivalent; 'addictive personality' ... 'alcoholic, addictive personality, lacks coping skills'. However the following two answers in response to the 'Anxiety' vignette were not considered to be equivalent; 'a bad experience has tainted her opinions on life' ... 'stress'. In relation to question 9, which asked what professionals vignette actors might need to see, answers were coded as equivalent when the same professionals were identified or alternatively professionals whose work was based on the similar foundations. For example 'psychiatrist' was coded as equivalent to 'doctor' or 'a medical professional'. Similarly

'psychologist' was coded as equivalent to 'counsellor' (as both offer talking based therapies) but not to 'doctor'. In some instances it was apparent that 'G.P.' was considered a 'first port of call' and on the second sitting the repsondent might have expanded to name a specific mental health care professional. In these few instances the answers, whilst not equivalent, did not seem to be contradictory either. Hence these instances were not included in the subsequent calculation of reliability.

This system of reliability coding could be considered as relatively generous, however it appeared to offer most face validity. The reliability ratings can be seen below in the accompanying table. (Please note that items 4-9 for question 3 relate to the constructs as presented in the questionnaire).

As can be seen the range of reliability scores for each individual item ranged from 30% to 100%, although only five scores were below 60%. Overall the reliability for this questionnaire was 81% and each vignette scored close to or above 80%. (Please note that items 4 - 9 for question 3 relate to the constructs as presented in order in the questionnaire.)

Table to show test-retest reliability percentages for the items following each vignette.

Qu.No.	Item	Area	Par.	Anx.	Alc.	Pho.	Dep.	Dem.
1	1	Recognition	100	90	100	100	100	90
2a	2	Interpretation	90	70	70	60	80	100
b	3		90	78	100	100	100	100
3	4	Causation	60	80	70	50	90	100
	5		60	100	90	80	70	70
	6		70	70	60	70	60	80
	7		60	70	30	60	80	80
	8		60	70	40	80	60	50
	9		60	80	70	50	50	70
4	10	Seriousness	100	90	90	90	80	100
5	11		100	100	100	100	100	100
6	12	Treatment	100	80	100	100	100	100
7	13		80	78	78	70	70	90
8	14		100	75	100	100	100	100
9	15		90	86	90	100	90	100
10	16		67	100	78	100	62	89
11	17	Recovery	100	60	78	30	60	100
12	18		80	30	90	80	60	89
Reliabilty rating:			81.5	78	80	79	78	89

Overall: 81%

APPENDIX 9

QUESTIONNAIRE PACK.

Please do not fill in this questionnaire unless you have read the Research Information sheet and signed a consent form.

All the people described herein are fictitious.

Please try not to discuss your answers with other people doing the questionnaire.

I am going to present some brief descriptions of people and of experiences which some people have during their lives.

Please read each description carefully and then answer the questions which follow.

There are no right or wrong answers and what I'm really interested in is what you as a member of the general public think is going on.

APPENDIX 10

1.) DO YOU THINK THIS PERSON HAS A **PROBLEM** ?

- [ ] YES
- [ ] NO
- [ ] DON'T KNOW

(tick as appropriate)

(If you answer 'no' please move onto the next Section.

If you answer 'don't know', then assume this person does have a problem and attempt to answer the following questions)

2a.) IF THIS PERSON HAS A PROBLEM, WHAT IS THE **NATURE** OF THEIR PROBLEM ?

(please tick the most appropriate from the following)

--- SOMETHING TO DO WITH THEIR PERSONALITY [ ]

--- SOME KIND OF MENTAL ILLNESS OR SOMETHING SIMILAR [ ]

--- A REACTION TO THEIR SITUATION OR TO SOMETHING WHICH HAS HAPPENED TO THEM [ ]

b.) IN YOUR **OWN WORDS**, WHAT DO YOU THINK IS THE PROBLEM ?

_____

_____

_____

_____

3.) WHAT DO YOU THINK MIGHT BE **CAUSING** THIS PROBLEM ?

(You may pick up to three of the following.

If you pick more than one, please number them in order of importance e.g. where

1 = most important,
2 = slightly less important
3 = least important...

Please also place an 'X' in the box if there any which you feel play no part at all)

--- SOMETHING BIOLOGICAL OR PHYSICAL ☐

--- WHAT WENT ON IN THIS PERSON'S CHILDHOOD ☐

--- DIFFICULTIES IN PERSONAL RELATIONSHIPS ☐

--- SOMETHING TO DO WITH THEIR PERSONALITY OR THE WAY THEY THINK ABOUT THINGS ☐

--- SOMETHING TO DO WITH THEIR SOCIAL SITUATION OR CIRCUMSTANCES ☐

--- STRESS OR PRESSURE FROM WHATS HAPPENING IN THEIR LIFE ☐

4.) DO YOU THINK THE PROBLEM IS **SERIOUS** ?

(tick one of the following)

VERY SERIOUS	SERIOUS	NOT SO SERIOUS	NOT AT ALL SERIOUS
☐	☐	☐	☐

5.) HOW MUCH DIFFICULTY MIGHT THIS PERSON CAUSE **THOSE AROUND THEM** ?

(tick one of the following)

A LOT OF DIFFICULTY	SOME DIFFICULTY	NOT MUCH DIFFICULTY	NO DIFFICULTY AT ALL
☐	☐	☐	☐

6.) DOES THIS PERSON **NEED HELP** ?

(tick one of the following)

☐ YES
☐ NO

7.) IF THIS PERSON NEEDS HELP, COULD THEY GET THE HELP THEY NEED FROM **FAMILY AND FRIENDS** ?

(tick one of the following)

☐ YES
☐ NO

8.) IF THIS PERSON NEEDS HELP, DO THEY NEED **PROFESSIONAL** HELP ?

(tick one of the following)

☐ YES
☐ NO

9.) IF YOU ANSWERED YES TO QUESTION EIGHT, **WHO** WOULD THEY NEED TO SEE ?

_____

_____

_____

10.) IN YOUR OPINION WOULD THIS PERSON **NEED** TO GO AND **STAY** IN A PSYCHIATRIC HOSPITAL TO GET BETTER ?

(tick one of the following)

☐ YES
☐ NO

11.) IN YOUR OPINION WHAT ARE THIS PERSONS CHANCES OF GETTING OVER THE PROBLEM **WITHOUT** PROFESSIONAL HELP ?

(tick one of the following)

--- WILL RECOVER COMPLETELY ☐

--- WILL RECOVER BUT THE PROBLEM WILL RECUR ☐

--- WILL RECOVER BUT WILL ALWAYS SHOW SIGNS OF HAVING HAD THIS PROBLEM ☐

--- WILL NEVER RECOVER ☐

12.) IN YOUR OPINION WHAT ARE THIS PERSONS CHANCES OF GETTING OVER THE PROBLEM **WITH** PROFESSIONAL HELP ?

(tick one of the following)

--- WILL RECOVER COMPLETELY ☐

--- WILL RECOVER BUT THE PROBLEM WILL RECUR ☐

--- WILL RECOVER BUT WILL ALWAYS SHOW SIGNS OF HAVING HAD THIS PROBLEM ☐

--- WILL NEVER RECOVER ☐

(Please move on to the next section)

In this next section I should like to ask for some information about you. It will remain entirely confidential.

Please continue.

INFORMATION SHEET.

SEX ☐ MALE ☐ FEMALE

AGE ? ☐

STATUS ☐ SINGLE ☐ MARRIED ☐ CO-HABITING ☐ WIDOWED ☐ SEPARATED/ DIVORCED

OCCUPATION _____

(If you are retired please state what your previous occupation was. If you are or were a housewife please state what your partner's occupation was.)

EDUCATION (Please tick level reached)

☐ PRIMARY
☐ SECONDARY
☐ COLLEGE OR UNIVERSITY
☐ OTHER (Please describe)

_____

_____

HAVE YOU EVER COME ACROSS ANY OF THE PROBLEMS DESCRIBED TODAY ?

☐ YES...

☐ SELF
☐ CLOSE FAMILY
☐ OTHER RELATIVE
☐ FRIEND OR WORKMATE
☐ OTHER (Please describe)

_____

_____

_____

☐ NO

☐ DON'T KNOW

(continued)

I'VE ASKED YOU TODAY TO COMMENT ON EXPERIENCES THAT SOME PEOPLE MAY HAVE IN THEIR LIVES. WHERE DO YOU FEEL YOUR VIEWS AND IDEAS HAVE COME FROM ?

(Please tick as appropriate. You may choose more than one.)

--- RADIO OR TV ☐

--- NEWSPAPERS AND MAGAZINES ☐

--- BOOKS ☐

--- FROM DISCUSSIONS WITH FAMILY, FRIENDS OR WORKMATES ☐

--- FROM GENERAL EDUCATION ☐

--- FROM YOUR G.P. ☐

--- FROM CONTACT WITH PSYCHIATRISTS ☐

--- FROM CONTACT WITH PSYCHOLOGISTS ☐

--- FROM CONTACT WITH COUNSELLORS ☐

--- FROM CONTACT WITH OTHER MENTAL HEALTH PROFESSIONALS ☐
(If so, who ? , i.e. what profession ?)

_____

_____

--- OTHER SOURCE
(Please describe) _____

_____

_____

_____

(End.)

Please state how you would describe your ethnic background (e.g. White, Afro-Caribbean, Asian etc.)

_____

Thankyou for your participation.

If you have any further comments on what you have read today, or on how it felt to take part, which you think it would be helpful for me know, please write them here.

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

SALOMONS CENTRE

RESEARCH INFORMATION

(Presented by Hedley Harnett)

I am a psychologist in clinical training on a doctoral programme within the National Health Service. I am interested in investigating how people from the general public and of different age groups view and make sense of certain types of experiences that people have.

I am inviting people to help me with this research. It involves reading some descriptions and answering some questions about whether the experiences described are problems and if they are, how they came about and what might be done to help. This is presented as a questionnaire.

There are no right or wrong answers. What I am really interested in is peoples individual views.

You might think that some of the experiences are problems or you might think that they are quite normal. You might even recognise some of the descriptions as being similar to yourself or to people who you know.

If you do decide that you would like to take part then the final part of the questionnaire will ask you some questions about yourself so that I will know something in general about you. However, you won't have to put your name on the questionnaire, so participation is anonymous and your answers will be entirely confidential.

You do not have to take part in this research and indeed if you do agree to take part then you can still pull out at anytime, even halfway through. The questionnaire will probably take about 30 minutes to fill in. I shall be present to help if there are any queries or concerns.

Overleaf is an example of the sort of description I would show you in the questionnaire. The person described is, of course, fictitious.

EXAMPLE:

Here's a person, let's call her Betty Smith. She has never had a job, and doesn't seem to want to go out and look for one. She is a very quiet person. She doesn't talk much to anyone - even to her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

(please turn over)

If you would like to take part please sign below.

"I have read and understood the above and consent to take part. I understand that I can withdraw at any time."

_____ Name

_____ Signature

_____ Date

NB This sheet with your name on it will be kept separate from your answers and cannot be connected with them.

WOULD YOU LIKE SOME FEEDBACK ?

If you would like to receive a short report on what the overall findings of this research are when I have finished, then please return this sheet to me at the address at the foot of the page before August '96.

NAME: _____

ADDRESS: _____

_____

_____

_____

Hedley Harnett, Psychologist in Clinical Training, Salomons Centre, Broomhill Road, Southboro', Nr. Tunbridge Wells, TN3 OTG.

APPENDIX 14

Salomons Centre
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Telephone: 01892 515152
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Our Ref: AL/LT/075
Direct Fax: 01892 518446
E-mail: tlavender@salomons.org.uk

SALOMONS CENTRE

18th March 1996

Mr H Hedley
Salomons Centre

Dear Hedley,

Re: Research Dissertation - Implicit models of mental disorder across the life-span: a comparison of older and younger adults

Enclosed is the Report of the Ethics Panel about your research. Conditional approval has been given and it was hoped that the conditions given would be relatively easy to meet and providing you met these foresaw no problems granting full approval. The Panel were very interested in the study and thought the work would prove most valuable.

We look forward to seeing the results and hope you enjoy the research.

Yours sincerely,

Dr A Lavender
Chair
Ethics Panel

Enc.

REPORT OF SALOMONS CENTRE/CLINICAL PSYCHOLOGY COURSE ETHICS PANEL

Research Dissertation

Hedley Harnett

Implicit models of mental disorder across the life-span: a comparison of older and younger adults

After careful consideration the Ethics Panel can give conditional approval for the Project. The conditions for approval are below:

1. The researcher should make it clear how access to individual participants is to be obtained through the identified organisations. Ethical issues are usually raised during gaining access and although the Panel were not overly concerned about the ethical issues likely to be raised by this part of the project it would like to know the procedure which will be followed.

2. The researcher should make a number of minor alterations to the research information sheet.

   (i) Replace the phrase in the third paragraph 'views of members of the general public' with 'people's individual views'. This is to avoid referring to the individual completing the form in a rather impersonal way that may give offence.
   (ii) Replace the phrase in the first paragraph of the second page 'who has helped me' with 'you'. This is to avoid putting undue pressure on participants.
   (iii) Adjust the time to complete the questionnaire to a more realistic minimum, that is half an hour. This will obviously become evident during the pilot but the panel were unable to complete the task in 15 minutes.

3. On the questionnaires, with question 2a) the panel had some difficulty with the task and would wish the researcher to consider the following observations:

   (i) With some vignettes raters may want to tick more than one of the boxes (i.e. the categories were not necessarily mutually exclusive).
   (ii) There was some uncertainty about whether 'nature' was the best word 'what are the reasons' was one suggestion and the range of options seemed restricted. It maybe that this questionnaire is following closely Barry's work and therefore any changes will have validity implications which mean the researcher is reluctant to alter the questionnaire. The proposal did not make it clear the extent to which the questionnaire has been adapted or whether new validity and reliability studies would be undertaken.

The Chair of the Panel would wish to know your response to the above as soon as possible.

Dr Tony Lavender
Director
Clinical Psychology
Training Scheme
18th March 1996

Ms Anne Tofts
Director
Development Programmes

Mr Michael Maltby
Top Grade Clinical
Psychology
Weald of Kent Community
NHS Trust

3rd April 1996

Hedley Harnett
CPTS (Salomons Centre)

Dr A. Lavender
Chair of Salomons Centre Ethics Panel
Salomons Centre

Dear Tony

Re: Ethics Committee / Research Dissertation - Implicit models of mental disorder across the life-span: a comparison of older and younger adults.

I would like to thank you and your fellow panel members for considering my submission. Your comments were very helpful. I hope that I can meet the requirements and address your points as follows:

(1) Individuals will be approached via their companies or organisations. This process is still at the negotiation stage and I will keep you informed as to how it develops. In most cases the procedure will be arranged with the personnel departments of the organisations involved. It may be that posters will be provided for the organisations involved for display in areas such as common rooms or canteens. The contact point will either be a designated individual at the organisation concerned or alternatively a 'phone number will be provided to contact Lynda

Thompson, the research organiser at Salomons, and when a reasonable number of potential participants have been canvassed a visit will be arranged. I will of course provide you with sight of any such poster before supplying it to said organisations. In some cases contact at organisations may be arranged through a person known to myself. Participation will of course remain entirely voluntary in all cases and the procedure with regards to information prior to participation and presentation of consent forms will be followed in the manner already outlined.

(2) With regards to (i),(ii) and (iii) all the suggestions have been implemented. Following piloting the questionnaire has been shortened by removing one of the vignettes (the second one, a mixed anxiety presentation) and the wording has been simplified in some places. The questionnaire is now described as taking 'about thirty minutes' to fill in.

(3) With regards to point (i) the wording has been changed to read 'please tick the most appropriate from the following' as opposed to 'please tick one of the following'. In relation to point (ii) the panel is correct in surmising that the form of words chosen closely follows the work of Barry (1991). The questions (with the exception of those added by myself) were presented by her in both closed and open-ended studies. The forced choice responses offered in the current piece of research derive from the responses she gained from her extensive open-ended study. It is hoped that some utility will be found in comparing the results from the current research with those found by Barry. For this reason I should like to keep the word 'nature' in my questionnaire. I hope that, following the presentation of

this additional information, the Panel are agreeable to this. I am of course willing to answer any further questions you may have with regard to this. Barry, as far as I have been able to surmise, did not carry out validity or reliability checks as part of her studies. On this basis I have endeavoured to address these issues in the manner previously outlined.

I am of course happy to answer any further questions you may have and will as stated keep you informed of further developments with regard to recruitment.

Thankyou again.

Yours sincerely

Hedley Harnett
Psychologist in Clinical Training

cc Margie Callanan.

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SALOMONS CENTRE

Mr H Harnett
28 Albury Street
Deptford
London SE8 3PS

10th April 1996

Dear Hedley,

Re: Research Dissertation - Ethics Panel Approval

Thank you for responding to the Ethics Panel's report and we are glad that you found the comments helpful. You have now clearly met all the conditions specified by the Ethics Panel and full approval is given. We would however, like you to send us a copy of the revised information sheet. It is important to restate that if the research is to include participants recruited from the NHS then Local Ethics Committee Approval must also be sought. The Panel understood from the proposal that this would not be the case but considered it important to draw attention to the issue in the event of this arising.

The Panel was extremely interested in the research, wish you well with the project and look forward to hearing about the outcome.

Yours sincerely,

Dr A Lavender
Chair
Ethics Panel

15 th May 1996

Hedley Harnett
CPTS (Salomons Centre)

Dr A. Lavender
Chair of Salomons Centre Ethics Panel
Salomons Centre

Dear Tony

Re: Ethics Committee / Research Dissertation - Implicit models of mental disorder across the life-span: a comparison of older and younger adults.

I am writing to keep you informed of my recruitment procedure in line with my letter of 3rd April. Following some difficulty in engaging various companies on a formal basis to allow me access to their workforces (for potential younger adult participants), I have given further thought to my approach. Following discussion with my research supervisor, Margie Callanan, I have adopted a more informal networking approach to recruitment. All previous procedural protocols are being adhered to and participation remains entirely voluntary. In addition, this approach may produce the benefit of a more various and representative sample.

I trust that this development is in keeping with the spirit of my original proposal and does not raise cause for concern. If you have any queries or wish further information please do not hesitate to address these to me.

Yours sincerely

Hedley Harnett
Psychologist in Clinical Training.

cc Margie Callanan

In relation to the 'paranoia' vignette, older adults generated the following labels: schizophrenia (4 cases), paranoid schizophrenia, inferiority complex, persecution complex (4 cases), persecution mania, mental depression, personality defect, paranoid, and slightly mental. Statements more orientated towards the origin or nature of the difficulties suggested that the person in the vignette was: lacking in confidence, very unsure of themselves, deluded; had an unreal view of others, might be hearing voices, and that their brain was ill. Other responses suggested that the person described had been neglected or shown a lack of love in their childhood (2 cases), had an insecure childhood (2 cases), had had an unfortunate experience, an unfortunate experience when young (2 cases), and that they had been picked on at school.

Younger adults in response to the same vignette generated the following labels: paranoid/oia (12 cases), mental illness, mental problem, persecution complex, schizophrenia, paranoid schizophrenia, classic schizophrenia, agoraphobia, severe depression. Other responses generated were that the person described: had an extreme distrust of others, felt physically threatened, was an aggressive person, who was unbalanced, insecure, had low self esteem, a psychological problem, a highly emotional personality, and no-one to talk to. Younger adults statements' indicative of the origin of the problem were that the person described had: been hurt by someone, felt insecure and lonely for a long time, was potentially experiencing the effects of drug abuse (2 cases), had had a bad past experience (5 cases),

and had been badly let down in the past. One younger adult stated that the problem was likely to have its roots in the person's upbringing but that it was aggravated by present surroundings and an absence of practical help. Another stated that the cause lay in childhood.

In relation to the 'alcoholism' vignette older adults generated the following responses: alcoholic/ism (6 cases), weak, weak personality, insecure, inadequate, drink dependency, addicted to drink, compulsive drinker, low self esteem (2 cases), and lack of control. They stated that the person described drunk to cope with life, needed to get themselves together, didn't realise how stupid they were being, didn't care about their family or themselves, had no meaningful relationships or sense of belonging or responsibility, and was caught in a vicious circle. Statements more orientated towards the origin of the problem suggested that the person described had: a lack of homelife, a problem at home, lost their mother or father in childhood, a physical problem arising from body chemistry, had something happen to them, and that their brain had snapped.

In relation to the same vignette, younger adults generated the following responses: alcoholic/ism (7 cases), addicted to alcohol (3 cases), alcohol problem, addictive personality, depression mainfesting itself in alcohol abuse, and a weak personality coupled with a negative environment. Younger adults stated that the person described was: drowning their problems (3 cases), blocking out reality (3 cases), avoiding pressures, and engaging in escapism (four cases). Other responses orientated towards the

origin of the problem suggested that the person had: something missing in their life, was unhappy with life, thought they were of no use, and had had some traumatic experience and wished to obliterate it. Three younger adults stated they thought the person trapped/caught in a vicious circle.

In relation to the 'phobia' vignette, older adults generated the following reponses: claustrophobia (9 cases), phobia, agoraphobia, fear of meeting people, fear of heights, delusion, doesn't face up to life, illness, and a physical disorder rather than a mental illness (2 cases). Responses orientated towards the origin of the problem stated that the person described had experienced: some shock such as a death, some physical situation in the past, being locked in sometime in their life, and some past experience which triggered a feeling of being trapped or shut in without escape.

In relation to the same vignette, younger adults generated the following responses: claustrophobia (18 cases), an irrational fear (3 cases), panic/panic attack (3 cases), anxiety/anxiety attack (2 cases), an inherent fear of closed spaces, a fear of crowds, a fear of being trapped, phobia getting out of hand - think he's going mental, and lack of confidence. Statements orientated to the origin of the problem indicated that younger adults considered it to be related to: past experience (2 cases), bad past experience, an experience in a closed space, and personality predisposition. One younger adult stated that in addition to such previous experience it could be triggered off by stress in another area of life.

In relation to the 'depression' vignette, older adults generated the following responses: depression/depressed (12 cases), severe depression, reactive depression, lonely (3 cases), uneasy with people, inadequate, lack of confidence in self, and little self worth. Other statements orientated to the origin of the problem were: something must have happened to them, they can't put the past away, and some situation - pressure - has triggered feelings of low self worth.

In relation to the same vignette, younger adults generated the following responses: depression/depressed (14 cases), severe depression (2 cases), deeply depressed, severe depression, depressive personality, in the process of some kind of breakdown, and in a cycle of feeling low and not being able to see any positive things in life. Other statements indicated that the person described felt: very unhappy and lonely, like a failure, like they were losing control of their life, a lack of direction, and a deep sense of loss. Responses orientated to the origin of the problem were as follows: suffered some loss (2 cases), old age - loss of partner, work/relationship problems, bad experience (2 cases), something must have happened to her, and external factors. One younger adult stated that whilst the depression probably stemmed from unresolved events, it might have altered the person's physiological chemistry over time.

In relation to the vignette depicting 'dementia', older adults generated the following responses: dementia/senile dementia (4 cases), severe dementia, early dementia, Alzheimer's disease (6 cases), the mind's ill, and physical/mental decay. Other responses, orientated to the origin of the problem were: some

illness is developing, problem is fairly physical, as a senior citizen - has lost faith, fear - lack of confidence, possibly a small loss of brain cells if the condition is not progressive, aging and a lack of B vitamins in diet, old age (2 cases), partly old age, and decline in old age. Remaining statements were: it sounds like what happens to elderly people, a fairly common confusion due to old age, and the forgetfulness that comes as one gets older. One older adult who in response to the earlier question answered that person in the vignette did not have a problem responded to this question 'senile, it happens to myself'.

In relation to the same vignette, younger adults generated the following responses: dementia/senile dementia (13 cases), senile/senility (3 cases), Alzheimer's disease (6 cases), early stages of Alzheimer's disease (2 cases), has had small strokes, amnesia, mental deterioration with age, forgetfulness with age, old age confusion, old age/problems of old age (8 cases), and quickened by lack of stimulation. One younger adult who answered 'don't know' to question one and had raised the issues of senility and Alzheimer's disease in relation to this question, added the statement, 'I wasn't sure if this was even a problem, as it is so common in elderly people'.

In relation to the 'paranoia' vignette older adults generated the following responses: psychiatrist (10 cases), counsellor (3 cases), psychologist (3 cases), doctor (3 cases), GP/family doctor (4 cases), social worker (2 cases), a psychiatric clinic, psychiatric service, psychotherapist, nurse, and a doctor with skills in mental health. One individual who cited the GP added that they thought the individual described was unlikely to take themselves there and another person stated that what was neede was, being able to talk one to one with somebody who really listens.

In relation to the same vignette younger adults generated the following responses: psychiatrist (13 cases), counsellor (13

In relation to the 'paranoia' vignette older adults generated the following responses: psychiatrist (10 cases), counsellor (3 cases), psychologist (3 cases), doctor (3 cases), GP/family doctor (4 cases), social worker (2 cases), a psychiatric clinic, psychiatric service, psychotherapist, nurse, and a doctor with skills in mental health. One individual who cited the GP added that they thought the individual described was unlikely to take themselves there and another person stated that what was neede was, being able to talk one to one with somebody who really listens.

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cases), psychologist (3 cases), doctor (3 cases), GP/family doctor (4 cases), social worker (2 cases), a psychiatric clinic, psychiatric service, psychotherapist, nurse, and a doctor with skills in mental health. One individual who cited the GP added that they thought the individual described was unlikely to take themselves there and another person stated that what was needed was, being able to talk one to one with somebody who really listens.

In relation to the same vignette younger adults generated the following responses: psychiatrist (13 cases), counsellor (13 cases), psychologist (6 cases), behavioural psychologist, clinical psychologist, doctor (3 cases), GP (2 cases), specialist counsellor, psychiatric nurse, the army, therapist, mental health specialist (2 cases), therapist who specialises in behavioural problems, and support group. Comments orientated to the nature of professional contact were: to build up trust and spend time with them, to talk through the problem, and an empathic ear is most important.

In relation to the 'alcoholism' vignette older adults generated the following responses: Alcoholics Anonymous (15 cases), psychiatrist (3 cases), doctor (3 cases), GP (3 cases), counsellor (2 cases), professional counsellor, social services, socila worker, Salvation Army, a stay in psychiatric hospital, a drug or alcohol dependency service, a drugs or alcohol professional, and an organisation which deals in this problem. One person added that what was important was having people prepared to listen without judging.

In relation to the same vignette younger adults generated the following responses: Alcoholics Anonymous (13 cases), counsellor (11 cases), psychiatrist (4 cases), doctor (6 cases), psychologist, behavioural psychologist, therapist, medical specialist, specialist in alcoholism, self help group, people in similar situation, and a professional.

In relation to the 'phobia' vignette older adults generated the following responses: psychiatrist (3 cases), psychologist (4 cases), counsellor (2 cases), doctor (3 cases), GP (2 cases), specialist (2 cases), clinic or hospital, a very high doctor, church minister, a group for therapy, professional and lay people who deal with this sort of thing, special clinic, psychotherapist, and behaviour modification programme. Other responses were: anyone who is interested enough to wish to help, are there tablets which might help ?, and I avoid situations where my phobia could be a problem.

In relation to the same vignette younger adults generated the following responses: psychiatrist (9 cases), counsellor (9 cases), psychologist (3 cases), doctor (2 cases), GP (2 cases), hypnotist (2 cases), a specialist, psychotherapist, support group specialising in phobias, other people with the same problem, a therapist, and a therapist who canprofessionally help her face this fear and discuss the reasons for it. One person who cited a psychiatrist stated that this would be to find out the root cause and reintroduce the person to situations that cause panic and control it.

In relation to the 'depression' vignette older adults generated the following responses: psychiatrist (5 cases), psychologist (3 cases), counsellor (6 cases), doctor (5 cases), GP/family doctor (7 cases), psychotherapist, social worker, and the Samaritans (2 cases). One participant who cited approaching a GP commented that this would lead to referral on, another that it would lead to medication. One participant thought that family and friends could help if they received professional advice and another that it might help if there were someone to take the person out, if only for an hour at first.

In relation to the same vignette younger adults generated the following responses: psychiatrist (8 cases), counsellor (14 cases), psychologist (2 cases), clinical psychologist, doctor (6 cases), GP (3 cases), homiopath or chemist, psychotherapist, psychiatric nurse, support group, and therapist (2 cases). Two participants referred to taking anti-depressant medication and another who cited a therapist as the appropriate professional to approach stated that this person would listen...make them look back at their life...and see good and bad there.

In relation to the 'dementia' vignette older adults generated the following responses: doctor (5 cases), GP (5 cases), psychiatrist (2 cases), social worker (2 cases), psychiatric unit, neurologist, geriatrician, a consultant in geriatrics, specialist in hospital, welfare community worker, a very high doctor, a carer, care eventually, and home help. In relation to the same vignette younger adults generated the following responses: doctor (4 cases), medical doctor, medical expert, counsellor (2 cases), psychiatrist, GP (5 cases), social worker,

social services, support group, nursing help, nursing home, sheltered housing, home help - to make sure they're eating/washing etc., old peoples' home, and a behavioural psychologist to help slow the condition down. One person who cited a GP stated that this would be to keep an eye on them as their ability to look after themselves diminished. Another person commented that drugs and medication might help.